ALTA CLAIMS
& INSURANCE SERVICES

CUSTOMIZED CONSULTING
Workers' Compensation

Strategic Approach
Innovative Solutions
Outstanding Outcomes

Cal State Univ

Workers' Compensation Manual 2024

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PART ONE | WHAT IS AN INJURY?

Labor Code § 5401 | Definition of an Injury

In California, injuries are categorized, and the actions needed based on these categorizations vary. Below is an outline and explanation of each.

First Aid
Labor Code § 5401 defines first aid as:

> ***"Claims requiring any one-time treatment, and any follow up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care.***
>
> ***This one-time treatment, and follow up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel."***

A first aid claim cannot include incidents in which the employee is exposed to a hazardous substance.

Medical Only
This is a claim in which the need for care surpassed that of a first aid claim, but the employee has not lost time from work and no lost time benefits are owed.

Indemnity/Lost Time Claim
This includes claims in which the employee is losing time from work that require the payment of lost time benefits. This can also include claims in which permanent impairment benefits are owed or the claim is denied.

Labor Code § 3208.1 | The Two Types of Injuries

Labor Code § 3208.1 states that an injury can be only one of two things:

- Specific, from a single incident or exposure that causes disability or the need for medical treatment, or

- Cumulative, manifesting over time from repetitive mental or physical trauma from activities extending over a period. The combined impact of the of the prolonged traumatic activities must cause disability or the need for medical care.

Labor Code § 5411 | Specific Injury

The date of injury is the date during the employment on which occurred the alleged incident or exposure which caused compensation to be claimed.

This code section is met for specific injuries. For example, a slip and fall resulting in a sprain.

Labor Code § 5412 | Cumulative Trauma Injury

The date of injury concerning a cumulative trauma injury including occupational disease is the date upon which the employee first suffered disability and either knew or in the exercise of reasonable diligence should have known, that the disability was caused by present or prior employment.

A good example of the purpose of this code section is mesothelioma when an employee was exposed to asbestos but did not suffer any disability until years later.

Division of Workers' Compensation | Definition of Disability

The Division of Workers' Compensation defines disability as "a physical or mental impairment that limits your life activities and makes engaging in physical, social, and work activities difficult."

Labor Code § 5500.5 | Employers Liable for Occ Disease or CT Injury

One of the principles of insurance is the principle of causa proxima. This means the direct or nearest cause. This principle tells us when there are a series of causes of losses or damages, the nearest or dominant cause is considered when calculating liability. This principle is used most often in property claims, but its basic doctrine is applicable when looking at the cause of an occupational disease or continuous trauma injury.

Labor Code § 5500.5, dating back to 1978, placed forth rules to limit the exposure to employers upon an employee sustained a continuous trauma claim. This is to limit the number of employers that could be brought in as defendants when an employee is asserting a continuous trauma injury as result of employment with each of their employers over many years.

This code states, "liability is limited to those employers who employed the employee during a period of one year immediately preceding either the date of injury, as determined by Labor Code § 5412, or the last date on which the employee was employed in an occupation exposing them to the hazards of the occupational disease or cumulative injury, whichever comes first."

Labor Code § 5405 | Time Limits for Benefits Collection Proceedings

Labor Code § 5405 outlines the Statute of Limitations to commence proceedings for the collection of medical and indemnity benefits is one year from any of the following:

- The date of injury.
- The expiration of any period of the payment of indemnity benefits.
- The last date on which medical benefits were provided.

PART TWO | KNOWLEDGE EMPLOYER'S DUTIES & RESPONSIBLITIES

Honeywell Decision | DWC-1 Claim Form | Labor Code § 5402

Labor Code § 5402(b) states:

> ***"If liability is not rejected within 90 days (for some job titles 75 days) after the date the claim form is filed under Section 5401, <u>the injury shall be presumed compensable under this division</u>. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period."***

This section has a strict interpretation that if the Claim Administrator does not act within the required timeframe after the DWC-1 Claim Form was filed by the employee, the claim could be presumed related to the job. This presumption can be overturned by presenting evidence after the 90-day period that could not have been reasonably obtained within the 90 day period.

Senate Bill 1127, effective for injuries occurring on or after January 1st, 2023, reduced the timeframe to investigate claims involving presumptive injuries dealing with police officers and firefighters from 90 to 75 days.

The Claims Administrator has a duty to conduct a good faith investigation from the date of the employer's knowledge of an injury once the employee has signed and returned the DWC-1 Claim Form.

The case of Honeywell v. WCAB (Wagner) was decided by the CA Supreme Court. As such, this is now the law of the land and citable when a party is attempting to show the Claim Administrator and/or Employer failed to conduct a timely investigation based on the filing of the DWC-1 Claim Form.

This case provided a four-step process to determine when the 90-day (presumptive injuries 75 day) period begins. It is itemized below.

- The employee bears the burden of notifying the employer of an injury.
- The employer then takes on the burden of informing the employee of his or her rights and providing a DWC-1 Claim Form.
- The burden then switches to the employee to return the completed DWC-1 Claim Form back to the employer or to "file the claim form" with the employer.
- Once the Employer and/or Claim Administrator is in receipt of the completed DWC-1 Claim Form they have the burden to conduct a timely good faith investigation to determine if the asserted injury arose out of and in the course of employment. As noted, this investigation must be completed within 90 days (75 days for some job titles) from the employer's date of knowledge an injury occurred.

So, the Honeywell decision begs the question. When is an employer required to provide the employee with a DWC-1 Claim Form?

Labor Code § 5401 | DWC-1 Claim Form

When Is a DWC-1 Claim Form Required?
The employer is required to provide the employee with the prescribed DWC-1 Claim Form within one working day of knowledge of an injury.

The injury must require medical care beyond first aid and/or results in lost time beyond the employee's work shift.

The DWC-1 Claim Form can be provided personally or by first-class mail.

When is a DWC-1 Claim Form *Not* Required?
Based on the above discussion, the DWC-1 Claim Form is not required when the claim is considered "First Aid" meaning the employee did not lose time beyond their work shift and/or require medical care beyond first aid.

First Aid
Labor Code § 5401(a) defines first aid as:

> ***"Claims requiring any one-time treatment, and any follow up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care.***
>
> ***This one-time treatment, and follow up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel."***

A first aid claim cannot include incidents in which the employee is exposed to a hazardous substance.

What is Contained in the DWC-1 Claim Form?
The form must include the notice of potential eligibility.

The claim form requests the injured employee's name and address, social security number, the time and address where the injury occurred, and the nature of and part of the body affected by the injury.

The notice of potential eligibility for benefits and the claim form is a single document The notice must be available in both English and Spanish.

The content includes the following:

- The procedure to be used to commence proceedings for the collection of compensation.
- A description of the diverse types of workers' compensation benefits.
- What happens to the claim form after it is filed.
- From whom the employee can obtain medical care for the injury.
- The role and function of the primary treating physician.
- The rights of an employee to select and change the treating physician

- How to get medical care while the claim is pending.
- The protections against discrimination provided pursuant to Section 132a.
- The following written statements:
    - You have a right to disagree with decisions affecting your claim.
    - To obtain valuable information about the workers' compensation claims process and your rights and obligations, go to [applicable Internet Web site(s)], or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling [applicable information and assistance telephone number(s)].
    - You can consult an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California.

Employee Filing the Claim Form
The completed claim form must be filed with the employer by the injured employee. A claim form is deemed filed when it is personally delivered to the employer or received by the employer by first-class or certified mail.

Employer Serving Completed Copy
A dated copy of the completed form must be provided by the employer to the employer's insurer and/or claims administrator and to the employee, dependent, or agent who filed the claim form.

Labor Code § 5402 | Authorizing Medical Care

Regardless of the validity of the claim, within one working day after an employee files a DWC-1 Claim Form, the employer must authorize medical treatment for the alleged injury. If the validity of the claim is questioned, care can only be stopped if the claim is denied, or the cost of care exceeds $10,000.00.

Labor Code § 5402(c) states:

> ***"Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with Section 5307.27, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000)."***

Medical care provided while a claim is investigated does not obligate the employer to a presumption of liability.

The employer has the right to direct the employee to a physician that is qualified to treat the injury.

Utilization review is discussed later concerning the ability to determine if medical care requested is reasonable and necessary. If the claim is questioned, medical care requested during investigation period, up to $10,000.00, is subject to utilization review.

Regulation § 10109 | Duty to Conduct Investigation; Duty of Good Faith

This regulation requires the claim administrator to conduct a "reasonable" investigation to secure information required to determine eligibility to benefits and provide each in a timely manner.

Must Gather Pertinent Information
"The claim administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information, whether that information requires, or excuses benefit payment."

Investigation Must Provide Needed Information and be Documented
"The investigation must supply the information needed to provide timely benefits and to document for audit the administrator's basis for claim decisions. The claims administrator must document in its claim file the investigatory acts undertaken and the information obtained as a result of the investigation. This documentation shall be retained in the claim file and available for audit review."

Employee's Onus to Prove Injury Does Not Excuse the Duty to Investigate
"The employee's burden of proof before the Appeal Board does not excuse the administrator's duty to investigate the claim."

Must Go Where the Investigation Leads
"The claims administrator may not restrict its investigation to the specific benefit claimed if the nature of the claim suggests that other benefits might also be due."

Information Received After the Initial Investigation
"The duty to investigate requires further investigation if the claims administrator receives later information, not covered in an earlier investigation, which might affect benefits due."

Claim Administrator Shall Deal Fairly and in Good Faith
"Insurers, self-insured employers and third-party administrators shall deal fairly and in good faith with all claimants, including lien claimants."

PART THREE | ARISING OUT OF & IN THE COURSE OF EMPLOYMENT

What Does AOE/COE Mean?

For an injury to be considered work related it must arise out of and occur in the course of employment. This two-pronged test allows for an employer to analyze the facts involved to determine if the injury is work related.

Arising out of

A compensable injury by accident must arise out of and occur in the course of employment. The phrase "arising out of" refers to the injury's origin and cause. For an injury to "arise out of employment, the injury must be proximately caused by the employment." Therefore, the employee must be injured while fulfilling work-related duties or engaging in something incidental to those duties.

In the Course of Employment

A compensable injury must also occur "in the course of employment" which refers to the time, place, and circumstances under which the accident occurred. Therefore, the injury must "occur within the period of employment at a place where the employee reasonably may be in the performance of their duties and while fulfilling those duties or engaged in something incidental thereto.

Labor Code § 3600 | Conditions of Compensation Liability

This code section provides criteria when determining if a claim is work related. It includes affirmative defenses that when met may result in a denial of compensation.

Employer-Employee Relationship

Independent contractors are not entitled to workers' compensation benefits. Thus, to qualify for benefits an employee-employer relationship must exist. California. Two tests exist when attempting to determine whether or not an employee-employer relationship exists.

ABC Test

In 2018 the California Supreme Court handed down a controversial decision concerning how those providing services to companies should be classified. This case involved a national package delivery company, Dynamex Operations West, that reclassified their employees as independent contractors, requiring them to use their own vehicles, pay for their own gas and other expenses. The California Supreme Court held Dynamex errored in the reclassification as these drivers were essential to company's core business. Later Assembly 5 was passed to codify the Dynamex decision establishing the ABC Test.

A: The worker is free from the control and direction of the hiring entity in relation to the performance of work, both under the contract and in fact.

B: The worker performs work that is outside the usual course of the hiring entity's business.

C: The worker is customarily engaged in an independently established trade, occupation, or business of the same nature as the work performed for the hirer.

Borello Test

In the event the ABC test does not fit the facts or needs in attempting to determine if an employee-employer relationship exists, the Borello test can still be used in determining if an independent contractor is an employee.

The California Supreme Court established the Borello test in S.G. Borello & Sons, Inc. v. Dept. of Industrial Relations (1989) 48 Cal.3d 341. The test relies upon multiple factors to make that determination, including whether the potential employer has all necessary control over the manner and means of accomplishing the result desired, although such control need not be direct, exercised or detailed. This factor, which is not dispositive, must be considered along with other factors, which include:

- Whether the worker performing services holds themselves out as being engaged in an occupation or business distinct from that of the employer;
- Whether the work is a regular or integral part of the employer's business;
- Whether the employer or the worker supplies the instrumentalities, tools, and the place for the worker doing the work;
- Whether the worker has invested in the business, such as in the equipment or materials required by their task;
- Whether the service provided requires a special skill;
- The kind of occupation, and whether the work is usually done under the direction of the employer or by a specialist without supervision;
- The worker's opportunity for profit or loss depending on their managerial skill;
- The length of time for which the services are to be performed;
- The degree of permanence of the working relationship;
- The method of payment, whether by time or by the job;
- Whether the worker hires their own employees;
- Whether the employer has a right to fire at will or whether a termination gives rise to an action for breach of contract; and
- Whether or not the worker and the potential employer believe they are creating an employer-employee relationship (this may be relevant, but the legal determination of employment status is not based on whether the parties believe they have an employer-employee relationship).

Borello is referred to as a “multifactor” test because it requires consideration of all potentially relevant facts – no single factor controls the determination. Courts have emphasized varied factors in the multifactor test depending on the circumstances. For example, where the employer does not control the work details, an employer-employee relationship may be found if (1) the employer retains control over the operation as a whole, (2) the worker’s duties are an integral part of the operation, and (3) the nature of the work makes detailed control unnecessary.

AOE/COE

When the injury occurred, the employee was engaged in a duty resulting out of and incidental to the employment and acting withing the course of employment.

Coming & Going Rule

This doctrine states that injuries sustained by the employee while traveling to and from work are not considered work related. The employer cannot reasonably control factors outside the workplace nor be responsible for injuries sustained when the employee is not engaged in performing their job.

Certain exceptions to the Coming and Going Rule apply. They are listed below:

- Company Provided Car: If the employee is provided with a car by their employer, injuries sustained while commuting to and from work would be considered work related.
- Traveling Between Job Sites: If the job requires the employee to travel between job sites or locations, an injury while on route to a job site invalidates the coming and going rule.
- Commercial Traveler: If the job requires the employee to travel to a work-related event, conference, meeting, etc. they will be covered for injuries sustained during this travel.
- Special Errand: If the employer requests the employee to run an errand an injury sustained during this errand could be work-related.
- Employer Control Over Property: If the employer designates employee parking or controls the property used for parking, an injury in the parking lot or turning into the parking lot may be considered work-related.
- Hazardous Condition: In some circumstances, the employer’s location can be considered in a hazardous location. An example could be only one route in or out of the parking lot caused by construction. Another could include the worksite being located in an area of town known to have a high rate of crime.

Coming and Going Rule Exceptions – Deviation Defense

For an injury to be considered work-related we must be able to establish that the injury arose out of and in the course of employment. It is a two-prong test that helps to establish if the injury is linked to work.

The deviation defense asserts that when the employee deviates from their job and is injured it may not be considered work-related. For example, the employer asks the employee to run an errand, picking up ink cartridges at a local retailer. In route, the employee remembers they need to pick up their dry cleaning and is rear-ended while turning into the dry cleaner's parking lot. The employee deviated from the errand and any injuries resulting from the auto accident may not be considered work-related because of the deviation.

When evaluating claims that fall under this doctrine, the timeline, path, and facts must be closely scrutinized to ensure the employee's injury arose out of and in the course of employment and not the result of a deviation that is clearly outside the employee performing duties that benefit the employer.

Personal Comfort Doctrine

This principle allows for injuries sustained on the job while the employee is attending to their health and wellbeing. These activities may not have arisen out of and in the course of employment, but benefits the employer as these activities are necessary for the employee to complete their job duties

A few examples include onsite meals and bathroom breaks. If the employee is off the clock and in the company break room eating lunch and slips and falls, this will most likely be considered work-related. However, if the employee leaves the worksite to secure lunch for themselves and injured while off the employees premises it may not be considered related to their job. This could change if they are off-site buying lunch for the team at their manager's request, as this would be considered a special errand.

Psychological Injuries

Labor Code § 3208.3 provides guidance around how to evaluate if the assertion of a psychological injury is work-related or if further investigation is warranted to determine relatedness. Below list outlines these criteria in detail.

Must Cause Disability or Need for Medical Treatment and Diagnosed

Labor Code § 3208.3(a) states that a psychological injury SHALL be compensable if it:

- causes disability or need for medical care;
- is diagnosed by a physician defined by the labor code, and
- the diagnosis using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or of other manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

Employment was the Predominate Cause or 51%
For the employee to have a work-related psychological injury, the employee shall demonstrate by a preponderance of the evidence that actual events of employment were predominant (51%) as to all causes combined of the psychiatric injury.

Victim or Exposed to a Violent Event, Substantial Cause, 35% to 40%
In the event the employee is a victim or exposed to a significant violent act, the employee shall be required to demonstrate by a preponderance of the evidence that actual events of the employment were a substantial cause of the injury. Substantial cause means 35% to 40% of the causation from all sources combined.

Six Month Rule
The employee must be employed with the employer for six months to be compensated for a psychiatric injury. The six months does not need to be a continuous period.

An exception exists in which compensation could be provided if the psychiatric injury is the result of a sudden and extraordinary event on the job.

Sudden & Extraordinary Events
This is defined as an event that is uncommon, unusual, and unexpected. There are many published decisions that have a common theme. Several of them deal with roofers, farm workers and others that commonly work at heights. The courts have come to a similar conclusion that it is not uncommon, unusual, or unexpected for a worker in this role to fall from a roof and ladder. Therefore, benefits for these employees were denied as they were employed for less than six months and could not establish their injuries were sudden and extraordinary in nature.

Psychiatric Claims Asserted Post Termination
In some instances, the employee may file a claim for psychiatric injury after receiving notice they are being terminated. This includes layoffs and voluntary layoffs. This deals with the assertion on the part of the employee of an injury being sustained prior to receiving notice of termination.

For an employee to receive compensation for an injury sustained prior to termination but claimed after termination, one or more of the following conditions must be met:

- Actual events of employment were the predominant cause of the psychiatric injury (51%) as to all causes combined.
- The injury was caused by sudden and extraordinary events at the job.
- The employer had notice of the psychiatric injury prior to notice of termination.
- The employee has medical records that show treatment for the psychiatric injury prior to the notice of termination.

- A finding of sexual or racial harassment by any trier of fact, whether contractual, administrative, regulatory, or judicial.
- Evidence that the date of injury is after the date of notice of termination, but prior to the effective date of the termination.

Lawful Nondiscriminatory Good Faith Personnel Actions
In some cases, the employee may secure compensation for a psychological injury resulting lawful nondiscriminatory good faith personal action. Examples usually include the employee experiencing stress and anxiety because of performance discussions linked to deficient performance. The burden of proof is on the individual asserting the issue.

No Fault System

The injury must be proximately caused by the employment. Negligence cannot be a factor in determining the proximate cause.

Intoxication

If the employee was intoxicated at the time of the injury, through the use of alcohol of a controlled substance, the claim can be denied if it can be shown the intoxication was the proximate cause of the injury.

Self-Infliction

Benefits can be denied when it is evident the employee's injury was self-inflicted.

Initial Physical Aggressor

If the injury is the result of an altercation benefits may be denied for any injuries sustained by the initial physical aggressor.

Commission of a Felony

Injuries sustained while in the commission of a felony, resulting in a conviction, are not considered work related.

Participation in an Off-Duty Recreational, Social, or Athletic Activity

Injuries sustained while engaging in these types of activities are usually not considered work-related unless the employer provided a reasonable expectation of participation, expressly or implied as part of the employment.

Post Termination Claims

No compensation is paid when the employee files a claim after notice of termination or layoff, including voluntary layoff unless the employee can demonstrate one of the following:

- The employer had notice/knowledge of the injury prior to the termination or layoff.
- The employee can provide medical records showing evidence of the injury prior to the notice of termination or layoff.
- The date of a specific injury is subsequent to the date of the notice of termination of layoff, but prior to the effective date of the termination or layoff.
- The date of a continuous trauma injury is after date of notice of termination or layoff.

Labor Code § 5402 & § 4650 | Timeframes to Investigate & Pay Benefits

Upon the employer having knowledge of an injury the claim administrator has 14 days from the employer's date of knowledge to pay, delay or deny benefits.

If more information is required to decide if the injury is work-related, the claim administrator can delay benefits for up to 90 days from the employer's date of knowledge.

Senate Bill 1127, effective for injuries occurring on or after January 1st, 2023, reduced the timeframe to investigate claim involving presumptive injuries dealing with police officers and firefighters from 90 to 75 days.

Required Benefit Notice Regarding Delaying Benefits
A "Notice Delay of Workers' Compensation Benefits" must be issued within 14 days of the employer's knowledge of the alleged injury. This notice must provide the correct decision date based on job type and a detailed explanation of what is needed by the claims administrator to decide if the injury is work-related. If the case is un-represented this notice must include the Panel QME Request Form 105 as an attachment. Make sure to list it as an attachment on the notice to receive credit during a State Profile Audit Review.

Labor Code § 4060 | Investigating AOE/COE

This code section does not apply when any part or parts of the body have been accepted as compensable by the employer.

Reports from the primary treating physician relating to determining AOE/COE is admissible as evidence.

Labor Code § 4060 can be interpreted that a medical evaluation is not required to determine AOE/COE. This is because claims can be questioned and denied based on legal and factual reasons. However, if a medical evaluation is required, Labor Code § 4060 provides the process for securing one if the employee is non-represented or has an attorney.

The process for securing a medical-legal evaluation for non-represented cases is outlined in Labor Code § 4062.1 and for represented cases in Labor Code § 4062.2.

Denying a Claim for Workers' Compensation

As discussed earlier, the claims administrator has 14 days to pay, delay or deny benefits.

The examiner should not wait until the 75th or 90th day to decide and instead decide as soon as the facts and results of the investigation allow.

There are three reasons why a claim should be denied.

Factual Disputes

A claim for workers' compensation can be denied based on a factual dispute. This could include an employee arriving first thing on Monday morning and claiming a back injury as a result of lifting an object. A co-worker reports that the employee injured their back playing softball over the weekend. This is a clear factual dispute that must be investigated fully in good faith prior to issuing a denial.

Legal Arguments

As noted previously, Labor Code § 3600 provides some affirmative defenses including intoxication, self-infliction, and post termination. In addition, a psychological injury cannot be asserted unless the employee has been employed for six months or more. This is not an exhaustive list of legal arguments concerning AOE/COE but some valid legal arguments that could lead to denying benefits.

Medical Disputes

The last element that can be used in denying a workers' compensation claim is a medical dispute. An example of a medical dispute could include an employee claiming carpal tunnel from a sudden traumatic event such as an automobile accident. Medical disputes can be resolved by the treating physician or a medical-legal evaluator.

Required Benefit Notice

Claims are denied by using the "Notice of Denial of Workers' Compensation Benefits" clearly stating the basis for the denial. If the denial is based on a medical report, the report must be attached to the denial. If the employee is unrepresented, the denial must include the Panel QME Request Form 105 as an attachment. Make sure to list all attachments on the notice to receive credit during a State Profile Audit Review.

Medical Legal Evaluations

Disputed Medical Fact

This can occur at the onset of the claim or at any time during and after the employee's recovery. If the case is being questioned and delayed because of a disputed medical fact a medical legal evaluation can be used to resolve the dispute.

A medical legal evaluator cannot be used to resolve disputes concerning the denial of a request for authorization of medical care through the Utilization Review process. This is to be resolved via the Independent Medical Review process.

Existence or Extent of Permanent Impairment
Either the employee or employer can use a medical-legal evaluation to dispute the existence or extent of permanent impairment.

Objections to Medical Determinations and Physician's Recommendations
Either the employee or employer can invoke the medical-legal evaluation process to resolve a dispute over a physician's recommendation. ***This cannot include the reasonableness or necessity of a medical treatment request.*** It can include things like, nature and extent of the injury, duration of temporary disability benefits and the specific diagnosis.

Medical legal evaluations can be conducted by the treating physician, qualified medical evaluator, or an agreed medical evaluator.

Treating Physician
The employer could request the treating physician to provide their opinion regarding the disputes listed for the different types of medical evaluations. This depends greatly on the treating physician's willingness to do so and their expertise in writing a medical report that meets substantial medical evidence. Substantial medical evidence is defined later.

Qualified Medical Evaluator (QME)
The QME is used largely in unrepresented cases to resolve the previously noted disputes. The employer or employee can request a QME. The party requesting a QME selects the desired specialty and submits the application to the State. The State sends the employee a list of three physicians to choose from and schedule an appointment.

Agreed Medical Evaluator (AME)
When the employee is represented by an attorney, the parties must first attempt to agree on a physician to resolve a dispute. When the parties are unable to agree on a physician, they must request a panel of QMEs from the State. Once in receipt of the panel, the parties can agree on a physician. If this is not possible, the parties are both allowed to strike one of the three physicians, with the remaining physician conducting the evaluation.

Process to Request a Panel Qualified Medical Evaluator

Timeframes to Object to a Medical Report

Represented Cases – the parties have 20 days from receipt of the medical report they are disputing to object in writing to the other party.

Non-represented Cases – the parties have 30 days from receipt of the medical report they are disputing to object in writing to the other party.

Non-represented Process to Request a Panel QME

Upon objecting to the primary treating physician's determination, the examiner should provide the injured worker with the Panel QME Request Form 105. The injured worker should be instructed to request a Panel of QME's from the State of California within 10 days of receiving the letter.

If the employee fails to request a Panel of QME's within the 10-day timeframe will allow the examiner to submit the request for the employee.

The party requesting the Panel of QME's will have the ability to specify the specialty required.

Within 10 days of the issuance of a panel of qualified medical evaluators, the employee must select a physician from the panel to prepare a medical evaluation, the employee must schedule the appointment, and the employee must inform the employer of the selection and the appointment.

If the employee does not inform the employer of the selection within 10 days of the assignment of a panel of qualified medical evaluators, then the employer may select the physician from the panel to prepare a medical evaluation.

If the employee informs the employer of the selection within 10 days of the assignment of the panel but has not made the appointment, or if the employer selects the physician pursuant to this subdivision, then the employer shall arrange the appointment.

Upon receipt of written notice of the appointment arrangements from the employee, or upon giving the employee notice of an appointment arranged by the employer, the employer shall furnish payment of estimated travel expense.

Represented Process to Request a Panel QME

In represented cases, the parties must first attempt to agree on a physician to resolve the dispute. This physician is the Agreed Medical Evaluator. If the parties cannot agree on a physician to conduct a medical-legal evaluation, they can utilize a State Panel Qualified Medical Evaluator. Below is the process to select one.

The process for requesting a Panel QME in a represented case is conducted electronically. There is no need to provide the opposing party with a request form.

First Working Day 10 Days After Mailing Request for a Med-Legal

Before either party can request a Panel of QME's, they must wait 10 days and make the request on the first working day after the expiration of the 10 days. The party submitting the request form shall serve a copy of the request form to the other party.

Advantage of Making the Panel QME Request

Given either party can make the request for a Panel of QME's, what is the advantage of being the first to complete the electronic request? The requesting party can specify the specialty of the QME panel.

Ability to Strike One of Three Physicians from the QME Panel

Within 10 days of assignment of the panel by the administrative director, each party may strike one name from the panel. The remaining qualified medical evaluator shall serve as the medical evaluator.

Party Fails to Timely Strike a Physician from the Panel

If a party fails to exercise the right to strike a name from the panel within 10 days of assignment of the panel by the administrative director, the other party may select any physician who remains on the panel to serve as the medical evaluator.

Represented Employee Must Arrange the Appointment

The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements. The employee shall not unreasonably refuse to participate in the evaluation.

Payment of Travel Expenses

Upon receipt of written notice of the appointment arrangements from the employee, or upon giving the employee notice of an appointment arranged by the employer, the employer shall furnish payment of estimated travel expense.

PART FOUR | MEDICAL CARE

Medical Care Provided by the Employer

Categories of Medical Care
For any benefits delivery system to be sustainable, guidelines must be put in place defining what is considered valid.

Labor Code § 4600 (a) provides this definition stating:

> ***"medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services."***

Reasonableness and Necessity of Care
After defining what care is, the next step is to determine if the care requested by the provider is reasonable and necessary.

Labor Code § 4600 (a) states:

> ***" that the employer is only required to provide care that is, "reasonably required to cure or relieve the injured worker from the effects of his or her injury."***

How is Reasonableness and Necessity of Care Determined?
Utilization Review (UR) is the mechanism to determine if care requested by the treating physician is reasonable and necessary. UR will be discussed in detail later.

Qualifiers and Timeframes in Providing Initial Medical Care

The employer has a requirement to provide medical care in the event of a work injury or the assertion of an injury.

First Aid
Labor Code § 5402 defines first aid claims as:

> ***"Claims requiring any one-time treatment, and any follow up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care."***

The employer must make sure to tend to any need for first aid care.

It is important to note that employers are not required to provide the employee with a DWC-1 Claim Form in cases of rendering first aid.

Labor Code § 5401 (a) is clear in stating:

> ***"Within one working day of receiving notice or knowledge of injury under section 5400 or 5402, which injury <u>results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid</u>, the employer shall provide, personally or by first-class mail, a claim form and notice of potential eligibility."***

Emergency Care
In the event an injury or incident requires emergency care, it should be provided immediately and without question to whether the need for care is related to a work injury.

Non-Emergency Care
California requires the employer to authorize and provide medical care regardless of the validity of the injury. This care is subject to Utilization Review. UR includes the Examiner authorizing care.

Providing Care on a Questionable Claim
Providing care in the face of an invalid or questionable claim does not obligate the employer to accept the claim as work-related.

Reasonable and Necessary Care Authorized w/I One Working Day
Reasonable and necessary care must be authorized within one working day after the employee has filed the DWC-1 Claim Form.

Labor Code § 5402 (c) states:

> ***"Within one working day after an employee files a claim form under Section 5401, the employer shall authorize the provision of all treatment, consistent with section 5307.27, for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000)."***

Labor Code § 5402(d) states:

> ***"Treatment provided under subdivision (c) shall not give rise to a presumption of liability on the part of the employer."***

Failure to Provide Medical Care
In the event the employer neglects to authorize care in accordance with the requirements of Labor Code § 5401(a) the employer may be found liable for the cost of medical care self-procured by the employee.

Labor Section § 4600 (a) states:

> ***"In the case of his or her neglect or refusal to reasonably do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment."***

Employee Predesignation of Physician

Upon hiring an employee, California law requires the employer to provide a "new hire" pamphlet. It provides information regarding rights to workers' compensation benefits in the event of an injury. Further it provides the name of the claim administrator and carrier, if applicable. This packet also provides a form for the employee to "predesignate" a physician to treat them in the event of a work-related injury.

Requirements of Physician Predesignation

- Employee must make the predesignation in writing prior to any injury
- The letter must outline the physician's name and address
- Specify the name of the insurance plan, policy or fund providing the employee with health care coverage for nonoccupational injuries
- The selected physician agrees to be predesignated prior to any work injury occurring
- This physician is the employee's primary care physician and has directed care in the past
- This physician is in control of the employee's medical records

Employer's 30 Days of Medical Control

Absent a medical provider network or health care organization, the employer has 30 days of medical control.

Upon notice of an injury, the employer can direct the employee to a physician of their choosing.

After 30 days from the date of injury the employee can select a treating physician within a reasonable geographic area.

Employee Requests Change of Physician

When the employer does not have a medical provider network (MPN) or health care organization (HCO) in place, the employer maintains 30 days of medical control.

Labor Code § 4601 however provides that the employee, at any time during the first 30 days, can request a change of physician. The employer has five working days from the date of the request to direct the employee to a new physician.

Physical Therapy, Chiropractic and Occupational Therapy Caps

Physical Therapy, Chiropractic and Occupational Therapy is capped at 24 visits each.

So, an employee could receive up to 72 visits per injury. UR is still the mechanism to determine the necessity of care, so employees do not automatically receive care at the cap, but up to the cap based on the injury and what UR determines as necessary.

If the employee has had surgery this type of care can be extended per Utilization Review.

Additional Visits Post Surgery
If the injured employee has had surgery, the 24-visit cap on PT, Occ Therapy and Chiro treatment does not apply. At that point, the employer can choose to authorize further care recommended or have this care go through the Utilization Review process to determine medical necessity.

Chiropractors and Acupuncturists

A chiropractor cannot serve as a secondary physician after the employee has received 24 chiropractic visits unless the employer authorizes it in writing.

Chiropractors and Acupuncturists cannot determine disability.

Definition of the Primary Treating Physician

California Regulation 9785 Defines the Primary Treating Physician as:

> ***"The physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter"***

This section also states that a Chiropractor shall not be a primary treating physician after the employee has received 24 Chiropractic visits unless the employer authorized additional visits in writing.

Definition of a Secondary Physician

California Regulation 9785 Defines A Secondary Physician as:

> ***"Any physician other that the primary treating physician who examiners or provides treatment to the employee but is not primarily responsible for continuing management of the care of the employee."***

Just like with the definition of the primary treating physician, when dealing with secondary physicians, a chiropractic cannot serve as secondary physician when the employee has received 24 Chiropractic visits, unless the employer authorizes additional visits in writing.

Primary Treating Physician Reporting Requirements

Form 5021 "Doctor's First Report of Occupational Injury or Illness
Within 5 working days following initial examination, a primary treating physician must submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form 5021.

Emergency and urgent care physicians must also submit a Form 5021 to the claims administrator following the initial visit to the treatment facility.

On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician must list:

- methods, frequency, and duration of planned treatment,
- specify planned consultations or referrals,
- surgery or hospitalization and
- specify the type, frequency, and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

Physician's Progress Report PR-2
The PR-2 is a prescribed form that provides periodic updates on the injured worker's progress in recovery. The form is comprised of sections. The top section allows the `physician to check off a box indicating the employee's status.

They range from:

- Periodic Report
- Change in Treatment Plan
- Release from Care
- Change in Work Status
- Need for Referral/Consultation
- Response to Request for Information
- Change in the Patient's Condition
- Need for Surgery or Hospitalization
- Request for Authorization

The PR-2 has a section for the patient and claim administrator information.

Two boxes are provided for the physician to note subjective complaints and objective findings.

Six boxes regarding the diagnosis.

An area to note the treatment plan.

Boxes to note the work status and need for any modifications. This includes if the employee can return to full duty.

A place for the physician's name, signature, and the date of the evaluation.

Physician's Progress Report PR-4
The PR-4 is utilized when the employee has reached maximum medical improvement. It cannot be used for a medical-legal evaluation.

Below are its relevant sections:

- Patient
- Claim Administrator
- Employer
- Description of How the Injury/Illness Occurred
- Patient's Complaints
- Objective Findings
- Physical Examination
- Diagnostic Test Results
- Diagnosis
- Impairment Rating
- Determination Regarding Apportionment
- Future Medical Care
- Comments

Reimbursement of Mileage

The injured worker is entitled to reimbursement for reasonable travel costs related to securing medical care. This can include fees for parking and tolls.

California mirrors the reimbursement rate of the Internal Revenue Service when calculating the amount payable to an injured worker.

The rate is adjusted annually as of January 1st of each year. The date of travel guides the reimbursement rate and not the date of injury.

Form, I&A Mileage Form, contains the necessary elements needed for the injured employee to properly request travel reimbursement. It is in English and Spanish. This form includes spaces for:

- Injured Worker's Name
- Claim Number
- Date of Travel
- Addresses Traveled To and From
- Round Trip Mileage
- Parking Fees
- Toll Fees
- Total Miles Multiplied by the Per Mile Reimbursement Rate

- Total Parking
- Total Reimbursement Requested
- Injured Worker's Signature
- Printed Name
- Date

Below is a grid of mileage reimbursement rates. Remember, reimbursement rates are based on the date traveled and not the date of injury. So, if a claim ages to the point of a mileage increase, the employee will be entitled to rate in effect on the date of travel.

Date Traveled	Cents Per Mile
On or After 1/1/2024	$.0.67
On or After 1/1/2023	$0.655
On or After 7/1/2022	$0.625
On or After 1/1/2022	$0.585
On or After 1/1/2021	$0.56

In the event the employer, carrier, administrative director, appeals board or a workers' compensation administrative law judge requests the employee to submit to an examination, the employee is entitled to mileage and tolls at the same time the employee is given notice regarding the time and place of the examination.

In addition to mileage and tolls the employee may also be entitled to reimbursement regarding the costs of reasonable lodging, meals and one day of temporary disability for each day of wages lost as a result of attending the examination.

Labor Code § 4600(e)(1) & (2) state:

> ***(e)(1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician, the employee is entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.***
>
> ***2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time the employee is given notification of the time and place of the examination.***

Timeframe to Reimburse Mileage and Tolls
As noted above, when the medical evaluation is set by the administrative director, the appeals board or administrative law judge, the administrator has 14 days to advance the mileage and tolls to the employee.

When the administrator requires the employee to attend an appointment, they must pay mileage at the same time the employee is given notice of the time and place of the examination.

When in receipt of a mileage, parking and toll reimbursement request from the injured worker, the administrator has 60 days to pay or object to the reimbursement request.

Payment of Medical Bills Labor Code §4603.2

Timeframes for Providers to Submit their Bill (30 days/180 days/12 months)

30 Days
As of January 1, 2018, when medical services are exempt from prospective utilization review, the bill must be submitted within 30 days from the date of service.

180 Days
As of January 1, 2018, if the medical care is for emergency services rendered in a general acute care hospital, the bill is required to be issued with 180 days of the care being provided.

12 Months
For medical services provided on or after January 1, 2017, the provider has 12 months to submit their bill from date of service or discharge regarding an inpatient stay.

Itemization and NPI Number Required
The request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer with the national provider identifier (NPI) number for the physician or provider who provided the service

Failure to include the physician's or provider's NPI shall result in the request for payment being barred until the physician's or provider's NPI is submitted with the request for payment.

Copies of Prescription Not Required
A copy of the prescription is not required with a request for payment for pharmacy services, unless the provider of services has entered into a written agreement that requires a copy of a prescription for a pharmacy service.

Nothing precludes an employer, insurer, pharmacy benefits manager, or third-party claims administrator from requesting a copy of the prescription during a review of any records of prescription drugs that were dispensed by a pharmacy.

Providers and Physicians Reimbursed per the Official Medical Fee Schedule
Unless care is provided under a contract authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer must be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service.

Timeframes to Pay a Medical Bill (Not an ebill)
Payments must be made by the employer with an explanation of review within 45calendar days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician.

Timeframes for Governmental Agencies to Pay a Medical Bill
When dealing with Governmental Entities the timeframes to pay properly submitted medical bills extends from 45 days to 60 days after receipt.

Timeframe to Pay a Medical Bill Submitted Electronically
Payments regarding uncontested amounts must be made by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1.

<u>If the billing is contested, denied, or incomplete, payment shall be made with an explanation of review of any uncontested amounts within 15 working days after electronic receipt of the billing.</u>

<u>Medical-Legal bills cannot be sent via e-bill</u>

Timeframe to Object to Medical Bills Including Ebills
If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer.

An explanation of review that states an itemization is incomplete shall also state all additional information required to decide.

Penalties for Late Payments
When a properly itemized and supported medical bill is not paid within the 45-day period, it must be paid at the rates in effect at the time of payment and increased by 15%, together with interest at the same rate as judgments in civil actions, retroactive to the date of receipt of the bill.

Duplicate Submissions of Medical Bills
Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical provider and are not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission.

Second Bill Review
If the provider disputes the amount paid, the provider may request a second bill review (SBR) within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue.

The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and must include all the following:

- The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.
- The item and amount in dispute.
- The additional payment requested and the reason, therefore.
- The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

Provider Fails to Request Second Bill Review Timely
If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

Employer Submits Final Written Decision to Request for SBR
Within 14 days of a request for second review, the employer must respond with a final written determination on each of the items or amounts in dispute.

Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

Independent Bill Review
The request for independent bill review must be made within 30 calendar days of the date of service of the final written determination issued by the claim administrator.

The request for independent bill review must be made in one of the following manners: Completing and electronically submitting the online Request for Independent Bill Review form, which can be accessed on the Internet at the Division of Workers' Compensation's website. Electronic payment of the required fee of $180.00 must be made at the time the request is submitted.

Mailing the Request for Independent Bill Review form, DWC Form IBR-1, and simultaneously paying the required fee of $180.00 as instructed on the form.

If IBR agrees with the provider's argument, the claim administrator must pay the balance owed and reimburse the provider the $180.00 review fee.

Utilization Review

California Labor Code 4610(a) defines Utilization Review as:

> ***"utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600."***

Emergency Medical Services
Emergency care cannot be delayed or impeded to conduct prospective utilization review.

Failure of the emergency care provider to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services.

Emergency health care services may be subjected to retrospective utilization review, which is explained later in this session.

Documentation for emergency health care services shall be made available to the claims administrator upon request.

Certain Cases Prospective Utilization Review Not Allowed for the First Thirty Days
California Senate Bill 1160 made several changes to Workers' Compensation effective January 1st, 2018. One change had the goal of providing care during the first 30 days of the injury in the most expeditious manner possible. Specifically, for employers or carriers that have put an MPN/HCO in place, or the employee is treating with a predesignated physician, care requested by the physician, which is contained in the utilization schedule, must be approved without the use of prospective UR.

Labor Code § 4610(b) states:

> ***"For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review"***

Exceptions to Labor Code § 4610(b)
However, not all care is passed through without prospective utilization review during the first 30 days of the injury. Below are some exceptions in which the employer or carrier can still conduct prospective utilization review to ensure it is reasonable and necessary.

- Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
- Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
- Psychological treatment services.
- Home health care services.
- Imaging and radiology services, excluding x-rays.
- All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
- Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
- Any other service designated and defined through rules adopted by the administrative director.

Physicians Still Required to Provide Reporting and Request for Authorization
If a physician fails to submit the report required under Section 6409 and a complete request for authorization, an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

Retrospective Utilization Review is Allowed to Determine Adverse Practices
An employer may perform retrospective utilization review for any treatment provided without prospective review during the first 30 days for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.

If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization to provide further medical treatment to any employee that is exempt from prospective utilization review.

The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant

to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

Establishing A Utilization Review Process is a Requirement
Each employer shall establish a utilization review process, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

Request for Authorization for a Course of Treatment
When the treating physician decides a specific type of treatment is warranted, they are required to provide the employer or carrier with a request for authorization. The physician must provide the request on the prescribed form, "DWC Form RFA." The form is contained in the California Code of Regulations, title 8, section 9785.5.

When is the RFA Deemed Received by the Claims Administrator or URO
The DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was electronically date stamped as received.

If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization.

A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA

RFA's Considered Incomplete
An RFA is considered incomplete when it:

- does not identify the employee or provider,
- does not identify a recommended treatment,
- is not accompanied by documentation substantiating the medical necessity for the requested treatment, or
- is not signed by the requesting physician or a non-physician reviewer.

The party receiving can regard the request as a complete DWC Form RFA and comply with the timeframes for decision or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt.

Claims Administrator Can Act on a Non RFA
The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that:

- "Request for Authorization" is clearly written at the top of the first page of the document;
- all requested medical services, goods, or items are listed on the first page; and
- the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

Provider Access to Claim Administrator
Every claim administrator shall maintain:

- Telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services.
- Have a facsimile number available for physicians to request authorization for medical services.
- Maintain a process to receive communications from health care providers requesting authorization for medical services after business hours by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

Calculating Timeframes to Conduct Utilization Review

What is the First Day of Receipt of the RFA
The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours.

Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

Type of Utilization Review, Timeframes and Requirements

Deferral of Utilization Review

Rationale to Defer UR
Utilization review of a medical treatment request made on the DWC Form RFA may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

Timeframes to Defer UR and Respond to the RFA
The deferral letter must be issued ***no later than five business days*** from receipt of the DWC Form RFA.

Notice Requirements
The written deferral decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

The written decision shall contain the following information specific to the request:

- The date on which the DWC Form RFA was first received.
- A description of the specific course of proposed medical treatment for which authorization was requested.
- A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
- A plain language statement advising the injured employee that any dispute shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

The following mandatory language must be included in the deferral notice advising the injured employee:

> "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."
>
> and
>
> "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

Dispute Leading to UR Deferral Resolved

Care Already Provided - Retrospective Review
In the event the dispute leading to the deferral of UR is resolved either by the WCAB or mutual agreement of the parties, the date for retrospective UR begins on the date the decision regarding liability becomes final.

Care Not Provided & Requested – Prospective Review
The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

Prospective and Concurrent Utilization Review

Timeframe to Issue a Prospective or Concurrent UR Determination
Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the

nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA.

Prospective and Concurrent UR – Imminent & Serious Threat to Health
The timeframe to make a prospective or concurrent review can be reduced from five (5) business days to 72 hours when the DWC RFA establishes that the injured worker faces an imminent and serious threat to his or her health. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request.

Retrospective Utilization Review

Timeframe to Issue a Retrospective Utilization Review Determination
Retrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

Determination Requirements

Decisions to Approve a Request for Authorization
All decisions to approve a request for authorization shall specify the specific the date the complete request for authorization was received, medical treatment service requested, the specific medical treatment service approved, and the date of the decision

Service Timeframes and Communication Requirements
For prospective, concurrent, or expedited review, approvals must be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail.

Communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

For retrospective review, a written decision to approve must be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

Payment Considered Approval & EOB Considered Notice
Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe to conduct retrospective utilization review will be deemed a retrospective approval, even if a portion of

the medical bill for the requested services is contested, denied, or considered incomplete.

A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

Decisions to Modify, Delay, or Deny a Request for Authorization

The review and decision to deny, delay, or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice

Prospective, Concurrent or Expedited Reviews
For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail.

The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

Retrospective Reviews
For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of request for authorization and medical information that is reasonably necessary to make a determination.

Further Requirements for a Denial of Concurrent Treatment

The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:

- Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee
- Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

When Can Timeframes to Make a UR Decision be Extended?

The timeframe to make a prospective or concurrent utilization review decision may only be extended under one or more of the following circumstances:

- The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.
- The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.
- The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

Requirements When Extending the Timeframe

If one of the above circumstances applies, a reviewer or non-physician reviewer must request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

In addition, the reviewer must also notify the requesting physician, injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer must also provide the anticipated date on which a decision will be made.

If the information reasonably necessary to make a determination that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

Upon receipt of the requested information the claims administrator or reviewer, for:

- prospective or concurrent review, must make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information.
- an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information.
- retrospective review, shall make the decision to approve, modify, delay, or deny the request for authorization within thirty (30) calendar days of receipt of the information requested.

The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision The written decision shall include the date the information was received, and the decision shall be communicated in the manner set out in section 9792.9.1(d) or (e), whichever is applicable

UR Denial Based on Lack of Medical Information

Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

Utilization Review Decision Remains in Effect for 12 Months

A utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claim administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Independent Medical Review

Employers Not Liable for Care Denied by UR
When a request for authorization is not approved or approved in part, any dispute is resolved by the Independent Medical Review (IMR) Process.

Unless the UR denial is overturned by the IMR process, the employer is not liable for any medical care procured without the authorization of the claim administrator.

Claim Administrator Obligation for the IMR Application
When sending the injured worker a utilization review denial, it must include a completed copy of the IMR application form (DWC IMR-1) to include an addressed envelope. Postage can be included on the addressed envelope but not required.

The IMR application form (DWC IMR-1) must be completed by the claim administrator or URO only requiring the injured employee to sign and date it.

The injured employee or eligible party must mail the request to:

DWC-IMR
c/o Maximus Federal Services, Inc.
PO Box 138009
Sacramento, CA 95813-8009

The form must clearly indicate the type of utilization review, either expedited or regular. Any expedited reviews must be accompanied by a physician’s statement on necessity as IMR can be completed on an expedited basis.

The IMR application must contain the WCIS number as referred to as the JCN.

Company Completing IMR
The state of California partnered with Maximus Federal Services, Inc. to conduct IMR. However, IMR decisions are considered those directly from the CA Administrative Director.

Timeframe for the Injured Work or other Eligible Party to Request IMR
A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claim administrator.

The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment.

At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment, to the claim administrator.

Who is an Eligible Party to Request IMR
A party eligible to file a request for independent medical review includes:

- The employee or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.
- An unrepresented employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf in filing an application for independent medical review under this subdivision.
- The physician whose request for authorization of medical treatment was delayed, denied, or modified may join with or otherwise assist the employee in seeking an independent medical review. The physician may submit documents on the employee's behalf pursuant to section 9792.10.5 (b) and may respond to any inquiry by the independent review organization.
- A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review under this section on its own behalf within 30 days after the service of the utilization review decision that either delays, denies, or modifies the provider's retrospective request for authorization of the emergency medical treatment.

IMR for Expedited Utilization Review
If expedited review is requested for a utilization review decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health.

Claim Administrator's UR Notice Defective
If the claims administrator provides the employee with a written utilization review determination modifying, delaying, or denying a treatment request that does not contain the required elements at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review will not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

Review of IMR Application
Following receipt of the Application for Independent Medical Review, DWC Form IMR, the Administrative Director must determine whether the disputed medical treatment identified in the application is eligible for independent medical review. In making this determination, the Administrative Director shall consider:

- The timeliness and completeness of the Application;
- Any previous application or request for independent medical review of the disputed medical treatment;
- Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.
- Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician.
- The employee's date of injury.
- The failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation.

Administrative Director's Request for Further Information
The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review.

The Administrative Director shall advise the claims administrator, the employee, if the employee is represented by counsel, the employee's attorney, and the requesting physician, as appropriate, by the most efficient means available.

The parties shall respond to any reasonable request within five (5) business days following receipt of the request.

Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review

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Disputes to the Administrative Director's Eligibility Determination

The parties may appeal an eligibility determination by the Administrative Director that a disputed medical treatment is not eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board.

IMR and Medical Records

Timeframes for the Claim Administrator to Send Records

Once the claims administrator is in receipt of the notification that the disputed medical treatment has been assigned for IMR, they have the following timeframes to submit records:

- Within fifteen (15) days following the mailing of the notification, or within twelve (12) days if the notification was sent electronically, or
- for expedited review within twenty-four (24) hours following receipt of the notification.

Required Records to be Sent to the IMR by the Claims Administrator

The independent medical review organization must receive from the claims administrator all of the following documents:

- A copy of all reports of the physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination.
- A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, which notified the employee that the disputed medical treatment was denied, delayed, or modified. Neither the written determination nor the application's instructions should be included.
- Other than the written determination by the claims administrator issued under, a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.
- A copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment.
- A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity.
- The claims administrator's response to any additional issues raised in the employee's application for independent medical review.

Itemization of Records Provided to the IMR
The claims administrator must, concurrent with the provision of records, forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization.

The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).

Any newly developed or discovered relevant medical records in the possession of the claims administrator after the documents are provided to the independent review organization shall be forwarded immediately to the independent review organization. The claims administrator shall concurrently provide a copy of medical records required by this subdivision to the employee, or the employee's representative, or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law.

Timeframes for the Claim Administrator to Send Records
Once the employee is in receipt of the notification that the disputed medical treatment has been assigned for IMR, they have the following timeframes to submit records:

- Within fifteen (15) days following the mailing of the notification, or within twelve (12) days if the notification was sent electronically, or
- for expedited review within twenty-four (24) hours following receipt of the notification.

Records to be Sent to the IMR by the Employee
The independent medical review organization must receive from the employee, if represented the employee's attorney, or any party identified in section 9792.10.1(b)(2), any of the following documents:

- The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.
- Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.
- Reasonable information supporting the position that the disputed medical treatment is or was medically necessary, including all information provided by the employee's treating physician, or any additional material that the employee believes is relevant.

The employee, if represented the employee's attorney or any party identified in section 9792.10.1(b)(2) shall, concurrent with the provision of documents under subdivision (b), forward the documents provided under subdivision (b) on the claims administrator, except that documents previously provided to the claims administrator need not be provided again if a list of those documents is served.

Any newly developed or discovered relevant medical records in the possession of the employee, if represented the employee's attorney, or any party identified in section

9792.10.1(b)(2), after the documents identified in subdivision (b) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The employee, if represented the employee's attorney, or any party identified in section 9792.10.1(b)(2), shall concurrently provide a copy of medical records required by this subdivision to the claims administrator, unless the offer of medical records is declined or otherwise prohibited by law.

IMR Requesting Further Records and Documents
At any time following the submission of documents), the independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary.

Additional documentation or other information requested under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

IMR Standards and Timeframes

IMR Process Can be Terminated
The independent medical review process may be terminated at any time upon notice by the claim administrator to the independent review organization that the disputed medical treatment has been authorized.

IMR Designation and Process Requirements
Upon assignment of the disputed medical treatment for independent medical review, the independent review organization shall designate a medical reviewer to conduct an examination of the documents/records submitted and issue a determination, using plain language where possible, as to whether the disputed medical treatment is medically necessary.

For independent medical review, “medically necessary” means medical treatment that is reasonably required to cure or relieve the employee of the effects of their injury.

Claims Administrator Fails to Provide Records
If a claims administrator fails to submit the required documentation/records, a medical reviewer may, issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination, and documents submitted by the employee or requesting physician. No independent medical review determination shall be issued based solely on the information provided by a utilization review determination.

More than One IMR can be Utilized
The independent review organization, upon written approval by the Administrative Director, may utilize more than one medical reviewer to reach a

determination regarding the medical necessity of a disputed medical treatment if it is found that the employee's condition and the disputed medical treatment is sufficiently complex such that a single reviewer could not reasonably address all disputed issues.

If more than one medical reviewer reviewed the case, the independent review organization shall provide each reviewer's determination.

The recommendation by a majority of medical reviewers shall prevail. If the reviewers are evenly split as to whether the disputed medical treatment should be provided, the decision shall be in favor of providing the treatment.

IMR Determination
The determination issued by the medical reviewer shall state whether the disputed medical treatment is medically necessary.

The determination must include:

- the employee's medical condition,
- a list of the documents reviewed,
- a statement of the disputed medical treatment,
- references to the specific medical and
- scientific evidence utilized and the clinical reasons regarding medical necessity.

The independent review organization shall provide the Administrative Director, the claims administrator, the employee, if represented the employee's attorney, and the employee's provider with a final determination regarding the medical necessity of the disputed medical treatment. With the final determination, the independent review organization shall provide a description of the qualifications of the medical reviewer, or reviewers and the determination issued by the medical reviewer.

The IMR's Name is Confidential
The independent review organization shall keep the names of the reviewer, or reviewers if applicable, confidential in all communications with entities or individuals outside the independent review organization.

Timeframes for the IMR's Final Determination
For regular review, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

If two (2) or more requests for independent medical review are consolidated under section 9792.10.4(a), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the last filed application for independent medical review that was consolidated for determination and the supporting documentation and information for that application.

If, under section 9792.10.1(d)(3), an internal utilization review appeal modifies a utilization review determination for which an application for independent medical review was previously filed under section 9792.10.1(b), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the application for independent medical review requesting review of the modified treatment, and the supporting documentation and information for that application.

For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5.

IMR Final Determination Binding
The final determination issued by the independent review organization shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.

Appealing the IMR's Decision
If a party wishes to appeal the decision made by the Administrative Director through the IMR process, they must file the appeal within 30 days of the date of mailing the determination to the employee or employer.

The determination of the Administrative Director through the IMR process is presumed correct and can only be set aside upon proving with clear and convincing evidence of one or more of the following grounds for appeal:

- The administrative director acted without or in excess of the administrative director's powers.
- The determination of the administrative director was procured by fraud.
- The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.
- The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.
- The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

IMR Payment for Review
The costs of independent medical review and the administration of the independent medical review system shall be borne by the claim administrators.

For each Application for Independent Medical Review, DWC Form IMR, assigned to an independent review organization for an independent medical review of a disputed medical treatment, the fee for the claims administrator shall be:

For regular review:

$550.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who:

is a physician as defined by Labor Code section 3209.3; and holds a M.D. or D.O. degree.

$740.00 If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers.

$475.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who:

is a physician as defined by Labor Code section 3209.3; and holds a degree other than an M.D. or D.O. degree.

$635.00 If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers.

For expedited review:

$645.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who:

is a physician as defined by Labor Code section 3209.3; and holds an M.D. or D.O. degree.

$830.00 If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers.

$575.00 for each application where a determination is issued under section 9792.10.6(b) by a medical reviewer who:

is a physician as defined by Labor Code section 3209.3; and holds a degree other than an M.D. or D.O. degree.

$740.00 If the review is conducted and a determination, or determinations if applicable, is issued by two medical reviewers.

For withdrawn reviews:

$215.00 for each application where review is terminated by the independent review organization prior to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer.

Payment of IMR Fees

The independent medical review organization shall bill each claims administrator for payment in arrears for every independent medical review initiated that was completed or terminated prior to completion.

Invoices shall identify each independent medical review, the fees assessed for each review, and the aggregate total fee owed by the claims administrator.

The aggregate total fee owed by the claims administrator for the prior calendar month shall be paid to the independent medical review organization within thirty (30) days of the billing. If the aggregate total fee is not paid within ten (10) days after it becomes due, there shall be added an additional amount equal to

10 percent, plus interest at the legal rate, which shall be paid at the same time but in addition to the total aggregate fee.

The fees paid by claims administrators for independent medical review under this section are non-refundable and not subject to discount or rebate. Any questions or disputes over the aggregate total fee and additional payments owed by the claims administrator under subdivision (c), late payments, and untimely determinations shall be submitted to the Administrative Director for informal resolution. Any request to resolve a dispute must be accompanied by a written statement setting forth the amount in dispute and the nature of the dispute.

Drug Formulary

As of January 1, 2018, California established a drug formulary for use in dispensing medications to injured workers. The California Medical Treatment Utilization Schedule was revised to include the pharmacy formulary.

It was established to achieve two main goals. First, to provide necessary medications to the injured worker without delay or need for prospective utilization review. Second, to ensure that injured workers were not receiving opioids unnecessarily.
The formulary drug list was established based on the drug's active ingredients.

At its core, the formulary established drug types and a specific path for each.

Exempt Drugs
A drug that is identified as "exempt" can be dispensed to the injured worker without obtaining authorization through prospective utilization review.

Some ***exceptions*** to this rule include:

- Brand name drugs
    - This requires the physician to justify why a brand name is required when a generic equivalent exists.
- Physician-dispensed medications
    - The physician can dispense up to a seven-day supply of a drug that is contained in the MTUS drug list without obtaining authorization through prospective review.
- Compound Drugs
    - Are always subject to prospective utilization review even if one or more of the ingredients is considered "exempt" on the MTUS drug list.

Non-Exempt Drugs
A drug that is identified as "Non-Exempt," requires authorization through prospective review prior to being dispensed. An expedited review should be conducted where it is warranted by the injured worker's condition.

Special Fills
In this category the MTUS Drug List identifies specific medications that are considered "Non-Exempt" but are allowed without prospective review.

The drug identified as a Special Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:

- The drug is prescribed at the single initial treatment visit following a workplace injury, provided that the initial visit is within 7 days of the date of injury; and
- The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List; and
- The prescription for the Special Fill-eligible drug is for:
    - An FDA-approved generic drug or single source brand name drug, or,
    - A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug, and the drug is prescribed in accordance with the MTUS Treatment Guidelines.

When calculating the 7-day period, the day after the date of injury is "day one."

An employer or insurer that has a contract with a pharmacy, pharmacy network, pharmacy benefit manager, or a medical provider network (MPN) that includes a pharmacy or pharmacies within the MPN, may provide for a longer Special Fill period or may cover additional drugs under the Special Fill policy pursuant to a pharmacy benefit contract or MPN contract.

Perioperative Fill
A perioperative drug is one that is prescribed and dispensed prior to and after a surgical procedure. The MTUS Drug List identifies drugs that are subject to the Perioperative Fill policy. Under this policy, the Non-Exempt drug identified as a Perioperative Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:

- The drug is prescribed during the perioperative period; and
- The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List; and
- The prescription for the Perioperative Fill - eligible drug is for:
    - An FDA-approved generic drug or single source brand name drug, or,
    - A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug, and the drug is prescribed in accordance with the MTUS Treatment Guidelines.

For purposes of this section, the perioperative period is defined as the period from 4 days prior to surgery to 4 days after surgery, with the day of surgery as "day zero".

An employer or insurer that has a contract with a pharmacy, pharmacy network, pharmacy benefit manager, or a medical provider network that includes a pharmacy or pharmacies within the MPN, may provide for a longer Perioperative Fill period or may

cover additional drugs under the Perioperative Fill policy pursuant to a pharmacy benefit contract or MPN contract.

Unlisted Drugs
For an unlisted drug, authorization through prospective review must be obtained prior to the time the drug is dispensed. A combination drug that is not on the MTUS Drug List is an unlisted drug even if the individual active ingredients are on the MTUS Drug List.

PART FIVE | INDUSTRIAL DISABILITY LEAVE

Industrial Disability Leave practices and procedures are adopted because of the interpretation and understanding of the California Education Code. Specifically, Title 3 Postsecondary Education, Division 8, California State University contains several code sections dealing with Industrial Disability Leave or IDL.

Education Code

Education Code 89529
Must PERS/STRS Member
This section defines entitlement to IDL. It states, "this article applies to employee of the trustees who are members of the Public Employees' Retirement System or the State Teachers' Retirement System in compensated employment on or after July 1, 1974."

Education Code 89529.02
Definitions
This section provides a definition for IDL and Full Pay. It reads:

'*Industrial disability leave means temporary disability as defined in Divisions 4(commencing with Section 3200) and 4.5 (commencing with Section 6100) of the Labor Code and includes any period in which the disability is permanent and stationary, and the disabled employee is undergoing vocational rehabilitation."*

"Full pay means the gross base pay earnable by the employee and subject to retirement contribution if he or she had not vacated his or her position."
This definition allows IDL to be paid in lieu of temporary disability benefits as the IDL definition links this benefit to temporary disability benefits.

Defining full pay allows this term to be used in other sections when describing when IDL represents full pay and when it does not.

Education Code 89529.03
Entitlement
This code section provides the requirements for an employee to be eligible to receive IDL benefits. Below is an outline:

- PERS/STRS Member
- Injury is Work Related

- Employee is Temporarily Disabled
- No Length of Service Required

Duration of IDL
The employee is entitled to 52 weeks of IDL within two years from the first date of disability.

First 22 Working Days of Disability
The payments must be in the amount of the employee's full pay less withholding based on his or her exemptions in effect on the date of his or her disability for federal income taxes, state income taxes, and social security taxes not to exceed 22 working days of disability.

IDL Post the First 22 Working Days
After the first 22 working days of disability, payment must be two-thirds of full pay.

Payments must be additionally adjusted to offset disability benefits the employee may receive from other employer-subsidized programs, except that no adjustment will be made for benefits to which the employee's family is entitled up to a maximum of three-quarters of full pay.

Contributions to the Public Employees' Retirement System must be deducted in the amount based on full pay.

Discretionary deductions of the employee including those for coverage under a state health benefits plan in which the employee is enrolled shall continue to be deducted unless canceled by the employee.

State employer contributions to the Public Employees' Retirement System must be made on the basis of full pay and state contributions pursuant because of the employee's enrollment in a health benefits plan must continue.

Education Code 89529.04
Continuation of Employee Benefits
An employee who is receiving industrial disability leave benefits must continue to receive all employee benefits which he or she would have received had he or she not incurred disability.

Education Code 89527
Supplementing IDL Payments, Post the First 22 Working Days, with Leave Credits
After the first 22 working days of full pay, IDL payments are reduced and paid at 2/3rds of the employee's salary. This education code provides the ability for the employee to supplement the remaining 1/3rd with sick leave credits.

This Education Code section states,

> ***"An officer or employee who is or may be entitled to temporary disability indemnity under Division 4 (commencing with Section 3200) or Division 4.5***

> ***(commencing with Section 6100) of the Labor Code shall receive any accumulated sick leave, or accumulated compensable overtime, or accumulated vacation for the absence. The trustees shall decrease the charge of sick leave, or compensable overtime, or vacation in*** **the amount of temporary disability payment received so that the officer or employee shall not receive payment in excess of full salary or wage."**

Timeframe to Elect IDL Regarding Supplementation
The employee has 15 days after the injury is reported to elect not to use accumulated sick leave or accumulated compensable overtime or accumulated vacation. If they do not make an election, it is presumed the employee wants to use leave credits to supplement the IDL benefits bringing them to full pay. Leave credits will be utilized until such time as the employee notifies the Campus in writing that they no longer wish to use accumulations to supplement IDL benefits.

Exhaustion of Leave Credits
When accumulated sick leave, overtime, or vacation are all exhausted the employee will be entitled to receive temporary disability indemnity benefits or IDL at two thirds of their full pay. However, it is important to note here the timeframes of entitlement. As stated previously, the employee is entitled to 52 weeks of IDL benefits within a two-year period of time. The existence of leave credits after 52 weeks does not extend IDL benefits beyond this timeframe.

Education Code 89529.05
Waiving IDL & Receiving Temporary Disability Benefits
The employee has the right to waive IDL entirely and receive temporary disability benefits. These benefits are paid directly to the employee by the claims administrator at two thirds of their average weekly wage, subject to a weekly maximum rate set by Statute.

Education Code 89529.07
IDL Expires Using Leave Credits to Supplement Temporary Disability Benefits
If the employee uses 52 weeks of IDL and continues to be off work as a result of the injury, they can use accumulated leave credits available to supplement temporary disability benefits and continue to receive their full pay.

Education Code 89529.08
Waiting Period for Commencement of IDL
IDL follows the same waiting period for the payment of temporary disability benefits.

This code section requires IDL to commence on the fourth calendar day after the employee leaves work as a result of an injury, unless:

- the injury causes disability exceeding 14 calendar days, or
- requires hospitalization.

In the event of these two events occur, the waiting period is waived and IDL commences on the first day of disability.

IDL Leave Elections and Summaries

Given the various Education Codes around Industrial Disability Leave or IDL, let's itemize and summarize these options and how they work.

The four leave options include:

- Industrial Disability Leave (IDL) Basic
- Industrial Disability Leave with Sick Leave Supplementation
- Temporary Disability (TD)
- Temporary Disability with Leave Supplementation

It is recommended that upon notice of lost time from work, the employee be supplied with an IDL benefits eligibility notice. The employee has fifteen days from receipt of this benefits eligibility notice to notify the Campus of their leave selection. If they do not provide a selection timely, they will be placed on IDL with any available leave being used to supplement the two thirds of IDL to full pay. If the employee does not have adequate leave credits, they will be placed on IDL basic consisting of two thirds of their pay without any leave supplementation.

Below is a detailed explanation of each of the four types of leaves available.

Industrial Disability Leave | Basic
Industrial Disability Leave (IDL) Basic is a benefit that pays up to twenty-two working days at full pay. If time lost exceeds twenty-two working days, the IDL benefit drops to 2/3rds of the employee's normal monthly gross salary.

IDL is available for a maximum of 52 weeks within a two-year period beginning with the first day of lost time from work.

When selecting to receive IDL Basic, certain deductions will continue from the employee's pay. This includes deductions for retirement, PERS contributions, elected health benefits, parking fees as well as any other voluntary deductions or withholdings that were Ordered.

Industrial Disability Leave | After 22 Workdays Using Sick Leave to Continue Full Pay
If the employee is off work for more than twenty-two working days, they have a one-time opportunity to elect IDL benefits utilizing accrued sick leave to supplement 1/3rd of their salary and continue receiving their full pay.

In order for an employee to elect to use sick leave to supplement IDL, they must have sufficient credits to provide an IDL supplementation in the amount equal to their regular daily salary or wage. The Campus will stop the supplementation when the amount is less than the employee's daily salary or wage.

Supplementation is limited to the use of sick leave accrued up to the date of the work-related injury or the first day of disability for which IDL with supplementation is sought.

If an employee is released to return to work but goes out on IDL at a later date for the same work-related injury, sick leave accrued during that time in work status may be used for supplementation purposes.

When selecting to receive IDL with sick leave to continue receiving full pay certain deductions will continue from the employee's pay. This includes, federal/state income tax, retirement, social security/Medicare, any applicable garnishments, PERS contributions, deferred compensation (457 or 401(k)), tax shelter (403(b)), elected health benefits, parking fees, pre-tax plans (HRCA, DCRA), any voluntary deductions and any withholdings that were Ordered.

Industrial Disability Leave | Eligibility Timeframes
An eligible employee may receive IDL payments for a period not to exceed 52 weeks within two (2) years from the first day of disability.

Temporary Disability
When IDL eligibility is terminated or the employee elects to receive temporary disability instead of IDL, the below is explanation of how these benefits are paid.

Temporary Disability payments are issued by the Third-Party Administrator (TPA) directly to the injured employee every two weeks.

TD payments are non-taxable. The weekly TD rate is based on two-thirds of the employee's average weekly wage determined by the date of injury and is subject to the minimum and maximum amounts set by California Statute. These rates are established by the Third-Party Claim Administrator.

TD payments have no mandatory or voluntary deductions withheld.

When receiving TD payments either by election or expiration of IDL, the employee is responsible to pay the full health coverage premium, which includes both their share and that of the Campus. Under these circumstances, the employee will need to coordinate with the Campus regarding their responsibility to pay the full premium.

Temporary Disability | Using Available Accrued Leave to Continue Full Pay
When IDL eligibility is terminated or the employee elects to receive temporary disability instead of IDL, other accrued leave credits can be used to bring them up to full pay.

In this option, accrued leave credits will be utilized to make up the difference between the full month gross pay and the temporary disability rate. Temporary disability is subject to California State Statutory minimum and maximum rates.

When selecting to receive temporary disability utilizing leave credits to receive full pay certain deductions will apply. This includes applicable federal/state income taxes, retirement, social security/Medicare, garnishments, PER contributions, deferred compensation (457 or 401(k)), tax shelter (403(b)), elected health benefits, parking fees, pre-tax plans (HRCA, DCRA), any voluntary deductions and any withholdings that were Ordered.

Employee Optional Election | One Time Opportunity to Change Benefits Election
Employees will be given a one-time opportunity to change their leave election.

At any time during the first ninety calendar days of absence, the disabled employee may notify his/her campus to change benefits from IDL to TD benefits or vice versa.

Such a change shall be a one-time opportunity and shall be effective on the 90th calendar day of absence.

PART SIX | INDEMNITY BENEFITS

Temporary Total Disability (TTD)

Entitlement
In the event an employee sustains an admitted injury, they are compensated when the primary treating physician deems, they are unable to work, or the employer cannot accommodate specific work restrictions noted by the physician. For example, the employee is a painter, the physician precludes work above shoulder level and no pushing/pulling/lifting over 10 lbs. The employer determines they cannot office a temporary reasonable accommodation and the employee is deemed temporarily totally disabled.

The employee is entitled to receive temporary disability benefits until such time as the physician states they can return to work, lifts the restrictions or the employer determines they can reasonably accommodate the temporary restrictions.

Waiting Period
Just like with other types of insurance coverage, such as short-term disability, benefits for time lost from work because of a work injury also has a waiting period. However, the waiting period is waived under certain circumstances.

Temporary Disability benefits are not payable for the first three calendar days unless the employee misses more than 14 calendar days from work or is hospitalized as an inpatient for treatment needed for the injury.

The date of injury does not count when calculating the waiting period unless the employer pays full wages for that day.

> Labor Code § 4652 states:
>
> ***"no temporary disability indemnity is recoverable for the disability suffered during the first three days after the employee leaves work as a result of the injury unless temporary disability continues for more than 14 days or the employee is hospitalized as an inpatient for treatment required by the injury, in either of which cases temporary disability indemnity shall be payable from***

> ***the date of disability. For the purposes of calculating the waiting period, the day of the injury shall be included unless the employee was paid full wages for that day."***

Calculating the Average Weekly Wage
Indemnity benefits including Temporary Total Disability are calculated utilizing the average weekly wage (AWW). It is critical that the average weekly wage be calculated correctly. The method of calculation is noted in Labor Code § 4453(c) 1 through 4 and is based on several factors noted below.

Earnings at an Irregular Rate or Specified by a Period of Time
If the earnings are at an irregular rate, such as piecework, or on a commission basis, or are specified to be by week, month, or other period, then the average weekly earnings shall be taken as the actual weekly earnings averaged for this period of time, not exceeding one year, as may conveniently be taken to determine an average weekly rate of pay.

30 or More Hours/Five or More Days a Week
Where the employment is for 30 or more hours a week and for five or more working days a week, the average earnings shall be the number of working days a week times the daily earnings at the time of the injury.

Less than 30 Hours
Where the employment is for less than 30 hours per week, or where for any reason the foregoing methods of arriving at the average weekly earnings cannot reasonably and fairly be applied, the average weekly earnings shall be taken at 100 percent of the sum which reasonably represents the average weekly earning capacity of the injured employee at the time of his or her injury, due consideration being given to his or her actual earnings from all sources and employments.

Working for Two or More Employers
Where the employee is working for two or more employers at or about the time of the injury, the average weekly earnings shall be taken as the aggregate of these earnings from all employments computed in terms of one week; but the earnings from employments other than the employment in which the injury occurred shall not be taken at a higher rate than the hourly rate paid at the time of the injury.

Minimum and Maximum Weekly Temporary Total Disability Rates
Weekly temporary total disability rates are set at a minimum and maximum rate.

Labor Code Section 4453(a) (10) requires:

> ***"the maximum and minimum weekly earnings upon which TTD is based be increased by an amount equal to percentage increase in the State Average Weekly Wage (SAWW) as compared to the prior year."***

The SAWW is defined as the average weekly wage paid to employees covered by unemployment insurance as reported by the U.S. Department of Labor for California for the 12 months ending March 31 in the year preceding the injury.

Below is a grid of weekly minimum and maximum temporary total disability rates along with the effective date and percentage change based on the SAWW.

The date of injury guides what rates will be paid.

Effective Date	Minimum Wkly Rate	Maximum Wkly Rate	SAWW Percent
January 1st, 2024	$242.86	$1,619.15	Decrease
January 1st, 2023	$242.86	$1,619.15	5.15924%
January 1st, 2022	$230.95	$1,539.71	13.5213%
January 1st, 2021	$203.44	$1,356.31	4.3774%
January 1st, 2020	$194.91	$1,299.43	3.84013%
January 1st, 2019	$187.71	$1,251,38	2.971%
January 1st, 2018	$182.29	$1,215.27	3.642%
January 1st, 2017	$175.88	$1,172.57	3.912%

Timeframes & Payment Cycles
The first payment of temporary disability indemnity must be paid no later than 14 days after the knowledge of injury and disability.

On the date of the first payment, all indemnity owed must be paid. Another way to think of this requirement is the payment through date must match the date of the check is being issued.

Labor Code § 4650(a) states:

> ***"If an injury causes temporary disability, the first payment of temporary disability indemnity shall be made not later than 14 days after knowledge of the injury and disability, on which date all indemnity then due shall be paid, unless liability for the injury is earlier denied."***

Each subsequent payment to the first payment must be issued every two weeks on the day designated with the first payment.

Labor Code § 4650(c) states:

> ***"Payment of temporary or permanent disability indemnity subsequent to the first payment shall be made as due every two weeks on the day designated with the first payment."***

Temporary Total Disability Paid Two Years After Injury
Often referred to as the "Two Year Rule" when TTD is paid two years after the date of injury, they are paid at the rates in effect at the two-year mark.

This can only result in an increase in the weekly TTD and never a decrease.

Labor Code § 4661.5 states:

> ***"when any temporary total disability indemnity payment is made two years or more from the date of injury, the amount of this payment shall be computed in accordance with the temporary disability indemnity average weekly earnings amount specified in Section 4453 in effect on the date each temporary total disability payment is made unless computing the payment on this basis produces a lower payment because of a reduction in the minimum average weekly earnings applicable under Section 4453."***

Cap on the Weeks of TD Paid
The maximum period that TD benefits can be paid is 104 weeks within 260 weeks from the date of injury.

Exceptions apply and if the employee sustains any of the below injuries, the timeframe is extended from 104 weeks to 240 weeks within a period of 260 weeks.

- Acute and chronic hepatitis B and C
- Amputations
- Severe burns
- HIV
- High velocity eye injuries
- Chemical burns to eyes
- Pulmonary fibrosis
- Chronic lung disease

Temporary Partial Disability (TPD)

Entitlement
In some cases, the primary treating physician may determine the employee should work reduced hours while recovering from the injury. In other cases, the employer may only have a modified job with reduced hours.

When this happens, the employee may be entitled to temporary partial disability (TPD) or also called wage loss.

Formula

Average Weekly Wage – Post Injury Weekly Wage = Wage Loss

Wage Loss X .667 = Weekly TPD Rate

Permanent Partial Disability (PPD)

Entitlement
The employee will receive reasonable and necessary medical care until the physician determines the employee's injury has reached a maximum medical improvement.

The physician is responsible for providing the whole person impairment rating or WPI based on the American Medical Association Guide for Evaluating Permanent Impairment, 5th Edition.

Body parts are assigned a chapter. For example, chapter 15 covers the spine. Impairment of the spine can be based on the diagnosis or range of motion.

The impairment rating provided by the physician must be adjusted for the employee's age and occupation.

The schedule for rating permanent disability is contained in the California Workers' Compensation Law of California, Table 11A. This schedule was revised in 2005 as part of Senate Bill 899.

In this example, a rating will be completed based on a spinal fracture to the lumbar spine impacting range of motion with an impairment rating of 10%. The employee is 45 years of age and works as a gas meter adjuster.

15.03.02.01 – 10 (1.4) – 14 – 320F – 14 – 15%

- 15.03.02.01 - Represents lumbar spine, fracture, range of motion
- 10 – Impairment rating (WPI)
- 14 – Rating after multiplying 1.4
- 320 – Designates the occupation
- F – Occupational variant
- 14 – Rating after occupational variant
- 15 – Rating after age adjustment

15% is equivalent to 50.50 weeks multiplied by the weekly PPD rate.

Permanent Partial Impairment Weekly Minimum and Maximum Rates
Just like with calculating the temporary total disability rate, PPD is set at a minimum and maximum weekly rate based on 2/3rds of the employee's average weekly wage.

As of January 1st, 2013, for permanent impairment ratings from 1% to 99% the minimum weekly PPD rate is $160.00, and the maximum rate is $290.00.

With our example, if the employee is entitled to the weekly maximum PPD rate of $290.00 it would be multiplied by 50.50 weeks totaling $14,645.00 payable.

Payment of PPD Benefits
Regardless of when PPD benefits are paid, they must be paid from the date TTD was terminated or the P&S/MMI date whichever is earlier.

> Labor Code § 4650(b)(2) states:
> *"the amount then due shall be calculated from the last date for which temporary disability indemnity was paid, or the date the employee's disability became permanent and stationary, whichever is earlier."*

The employer is required to pay a reasonable estimate of permanent disability benefits within 14 days of the last payment of temporary disability benefits.

If it is not possible to determine a reasonable estimate, the determination of permanent disability benefits can be delayed until such time as a reasonable estimate is possible.

> Labor Code 4650(b)(1) states:
> *"When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of Section 4656, and regardless of whether the extent of permanent disability can be determined at that date, the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined, until that amount has been paid.*

Deferring the Payment of PPD Benefits
It is possible to defer the payment of PPD benefits until the parties are in receipt of an award for permanent disability. However, certain criteria must be met to allow for permanent impairment payments to be deferred.

PD benefits can be deferred when:

- The employer has offered the employee a position that pays at least 85% of the wages and compensation paid to the employee at the time of the injury, or
- If the employee is employed in a position that pays at least 100% of the wages and compensation paid to the employee at the time of the injury.

> Labor Code § 4650(b)(2) states:
> *"Prior to an award of permanent disability indemnity, a permanent disability indemnity payment shall not be required if the employer has offered the employee a position that pays at least 85 percent of the wages and compensation paid to the employee at the time of injury or if the employee is employed in a position that pays at least 100 percent of the wages and compensation paid to the employee at the time of injury, provided that when an award of permanent disability indemnity is made*

Apportionment

Requirement as Part of a Valid MMI Report
For a PR-4 or medical legal evaluation to be considered valid it must address the issue of causation of permanent disability. For the report to be considered complete it must include an apportionment determination.

Physician Apportionment Determination
A physician must make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.

Physician Cannot Make an Apportionment Determination
If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury.

The physician must then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

Employee Must Disclose Prior Permanent Disabilities and Physical Impairments
An employee who claims an industrial injury must, upon request, disclose all previous permanent disabilities or physical impairments.

Apportionment to Prior Awards
If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

The Benson Decision
This case involved an injured worker that claimed a specific injury on June 3, 2003, to the neck which required surgery. During an Agreed Medical Evaluation, the Evaluator found that the employee also sustained a continuous trauma claim through June 3, 2003. Further, the specific and continuous trauma injuries reached a maximum medical improvement simultaneously. The AME apportioned 50% of the permanent impairment to the specific injury and 50% to the continuous trauma case. The parties agreed that the permanent impairment ratings combined was 62% or $67,016.25.

The WCJ relied on the guidance provided in the prior Wilkinson decision when combining the two ratings.

The employer filed a petition for reconsideration arguing the approach adopted as a result of Wilkinson was no longer valid as it was inconsistent with changes to apportionment and Labor Codes 4663 and 4664, which technically prohibits the impairments ratings from the specific and continuous trauma injury be combined. Instead, they must stand on their own at 31% each. Two separate awards would be equal to $49,210.00 and much less than if they were combined.

The Workers' Compensation Appeals Board agreed and issued an en banc decision ruling that the approach adopted from the Wilkinson case is not consistent with the new requirements that apportionment be based on causation. The Applicant filed a Writ with the Court of Appeal. They affirmed the WCAB's decision.

The Benson decision along with Labor Code Sections 4663 and 4664, mandate that permanent disability caused by multiple and continuous injuries to the same parts of the body be ***separately apportioned*** between the multiple injuries instead to a single combined award of permanent disability. There are exceptions in "limited circumstances."

In "limited circumstances" or in "rare instances", the physicians may state they cannot medically parcel out the approximate percentage to which each separate injury is causally contributing to the applicant's overall permanent disability to the same body part or condition. The physician is required to provide an opinion based upon a plausible non-conclusory analysis and reasoning as to why they are unable to do so in order for their opinion to constitute substantial medical evidence.

> The physician's opinion will not meet the level of substantial medical evidence, when asserting the "limited circumstances" exception to *Benson* should not be deemed triggered or established by a physician stating the permanent disability attributable to multiple injuries is "inextricably intertwined."
>
> Attempting to do so would serve to transform the "limited circumstances" exception recognized in *Benson* into the general rule which would be inconsistent with Labor Code sections 4663 and 4664 and applicable case law.

Life Pension

In the event an employee's permanent impairment meets or exceeds 70% to 99% the employee will be entitled to a life pension. Once permanent impairment is paid in full, the §employer will be obligated to immediately start life pension payments for the remainder of the employee's life.

Calculating Life Pension
The formula for calculating life pension is as follows:

(PD Impairment Rating – 60) (.015) (AWW)

The AWW is subject to a maximum per Labor Code § 4659(a). As of January 1, 2006, the average weekly wage used to calculate Life Pension benefits cannot exceed $515.38 a week. Below are the steps to calculate the weekly LP rate.

1. Subtract the PD rating from 60. For example, the employee has a final PD rating of 84.

   84-60 = 24

2. Multiply 24 by .015

   24 x .015 = .36

3. Multiply .36 by the Average Weekly Wage (Maximum LP weekly rate is $515.38). In this example the AWW is $1,589.00.

   .36 x $515.38 = $185.54

Life Pension Subject to SAWW Increase
Labor Code Section 4659(c), states workers with a date of injury on or after January 1, 2003, receiving life pension (LP) are entitled to have their weekly LP rate adjusted based on the SAWW.

Permanent Total Disability (PTD)

Entitlement
Labor Code § 4662 provides the types of injuries that are presumed to cause 100% permanent total disability.

Any of the following permanent disabilities shall be conclusively presumed to be total in character:
(1) Loss of both eyes or the sight thereof.
(2) Loss of both hands or the use thereof.
(3) An injury resulting in a practically total paralysis.
(4) An injury to the brain resulting in permanent mental incapacity.

In all other cases, permanent total disability shall be determined in accordance with the fact.

Weekly PTD Rate
PTD is paid at the weekly TTD rate for the employee's lifetime.

PTD Subject to SAWW Increase
Labor Code Section 4659(c), states workers with a date of injury on or after January 1, 2003, receiving PTD benefits are entitled to have their weekly PTD rate adjusted based on the SAWW.

Penalties

Entitlement
Penalties owed because of making late indemnity payments *are self-imposed* meaning the administrator must realize and pay these penalties without any action on the part of the injured worker or their attorney.

Labor Code 4650
This code section requires any indemnity payment to be issued within 14 days of knowledge it is payable. Subsequent payments must be issued every 14 days thereafter on the day of the week designated by the first payment.

If any payment is not made in time, the amount of the late payment must be increased by 10 percent.

The Protected Period
No increase will apply to any payment due prior to or within 14 days after the date the claim was submitted to the employer under Labor Code § 5401.

Death Benefits

Benefits Owed When an Employee Passes Unrelated to the Injury
In the event an injured worker passes away while a claim is active for reasons unrelated to the injury, any accrued and unpaid compensation shall be paid to their dependents, or heirs, without the need of these individuals requesting payment.

Labor Code § 4700 states:

> ***"The death of an injured employee does not affect the liability of the employer under Articles 2 (commencing with Section 4600) and 3 (commencing with Section 4650). Neither temporary nor permanent disability payments shall be made for any period of time subsequent to the death of the employee. Any accrued and unpaid compensation shall be paid to the dependents, or, if there are no dependents, to the personal representative of the deceased employee or heirs or other persons entitled thereto, without administration."***

It is important to note this applies to accrued and unpaid compensation and not future compensation that is owed or estimated to be owed.

Death Benefits
Death benefits can be payable in the event an employee is killed on the job or passes away after the date of injury and the death can be linked to the injury in some way.

The benefits can vary depending on the number and type of dependents left behind.

Just like any other assertion of an injury, a death claim can be delayed for an investigation.

It is not recommended a death claim be delayed determining dependency. The two issues are separate and distinct from each other.

Below is an explanation of each component in more detail.

Burial Expenses
In an admitted death claim burial expenses are paid at $10,000.00 for injuries on or after January 1, 2013. For injuries prior to January 1, 2013, burial expenses are paid at $5,000.00. It is important to note, this is not a reimbursement, it is a benefit paid for burial expenses.

Dependency
The amount of the death benefit payable will depend on the date of loss and the number of partial and total dependents. The labor code defines what is considered a presumed total dependent and some guidance on how to determine partial dependency. The below itemizes each

Presumed Total Dependent
Per Labor Code § 3501 the below individuals qualify as total dependents if they meet specified criteria.

Child of the Deceased Under 18 Years of Age
A child of the deceased parent shall be conclusively presumed to be wholly dependent for support upon the deceased parent if the minor child meets two factors. They include:

- The child is living with the deceased parent at the time of death; or
- It can be proven that the deceased parent was financially responsible for the minor child.

Physically or Mentally Incapacitated Children
When it can be demonstrated that a child of a deceased employee is unable from working, they could be conclusively presumed a total dependent and entitled to lifetime benefits. They must meet the same criteria as the minor child dealing with living with the parent or being dependent upon the deceased financially.

Spouse of the Deceased Employee
If the deceased employee's spouse earned $30,000.00 or less in the year proceeding the death, they are conclusively presumed to be a total dependent.

Putative Spouse
This deals with a spouse that asserts in good faith to be married to the deceased, but it is later discovered this is not the case. In some cases, this individual may still be treated as a spouse for the sake of determining dependency and entitlement to death benefits.

Domestic Partners
A registered domestic partnership extends the same conclusive presumption of dependency as a spouse, given the same eligibility criteria.

Factual Determination of Dependency
Dependency is based on a determination of the facts that exist at the time the employee was injured. So, for anyone that is conclusively presumed a dependent, must present facts that would establish their dependency upon the deceased employee for their livelihood.

Qualifications for Dependency
Per Labor Code § 3503, dependency can be established by demonstrating the individual was a member of the family or household. In addition, dependency can be established by showing a familial relationship. This is in addition to proving the deceased partially or fully contributed to the household or family members livelihood.

The familial link is defined in this labor code section as:

- Spouse
- Child. Adopted Child, Stepchild
- Grandchild
- Father or Mother
- Father-In-Law or Mother-In-Law
- Grandfather or Grandmother
- Brother or Sister
- Uncle or Aunt
- Brother-In-Law or Sister-In-Law
- Nephew or Niece

Compensation Based on Dependents
The below grid provides the total amount of benefits owed based on the number of dependents before and after January 1st, 2013.

Dates	Burial Expenses	1 Total Dependent	2 or More Total Dependents	3 or More Total Dependents	1 Total Dependent Plus 1 or More Partial Dependents	1 or More Partial Dependents
Injuries on or after Jan. 1, 2013	$10,000	$250,000	$290,000	$320,000	$250,00 plus four times annual support for partial dependents not to exceed $290,000	Eight times annual support not to exceed $250,000

Payment of Death Benefits
Unless the parties enter into a settlement agreement that differs, death benefits are paid at the employee's weekly temporary disability subject to minimum and maximum rates set at the date of injury.

If the case involves minor children that have met the burden to be considered a dependent, benefits are paid at the temporary disability rate until the youngest child reaches the age of 18.

If the child is shown to be mentally or physically incapacitated from working and meets the burden to be considered a dependent, benefits are paid at the temporary disability rate for the remainder of their life.

PART SEVEN | SELF INSURANCE

According to the California Department of Industrial Relations Website, California has the largest workers' compensation self-insurance program in the nation. As of January 1, 2023, 6,939 California employers are actively self-insured.

Public entities are presumed to be self-insured; however, this does not preclude them from purchasing a workers' compensation policy from carrier.

The employer has applied and was approved by the State of California to pay their workers' compensation claims without purchasing an insurance policy. In most cases, the employer will purchase an excess policy in the event of a costly or catastrophic case occurring.

Employers can also group together, in similarly situated businesses, to combine resources to self-insure. Today many Self-Insured Groups or SIGs exist in many different types of verticals. They range from School Districts, Car Dealerships, Plumbers, and Non-Profits.

There are many benefits when comparing self-insurance to purchasing an insurance policy. One is greater control over their claims program, including the selection of the third-party administrator.

This section will review all aspects of self-insurance and the various requirements it imposes on employers and claim administrators.

Office of Self Insurance Plans (OSIP)
OSIP is a program reporting to the director's office of the Department of Industrial Relations (DIR). OSIP is responsible for:

- Vetting and potentially approving employer's and self-insured groups applying to become self-insured
- Reviewing and possibly revising regulations governing the handling of self-insured employers and resulting claims
- Ensuring that reserves placed on files are adequate in the event the employer defaults
- Reviewing required annual reporting from self-insured employers
- Conducting audits of reserving and claims handling of claim administrators handling self-insured employer's claims
- Possibly revoking an employer's certificate to self-insure if they are found to not follow the regulations and/or unwilling to comply
- Managing assessments collected from employers that self-insure per Labor Code 62.5.

As of January 1st, 2024, Lynn Asio Booz is the Chief of the Office of Self Insurance Plans.

Assessments Owed to the State by Self-Insured Employers
When an employer purchases an insurance policy, they will pay various fees through the carrier to the State. When the employer decides to self-insure their workers' compensation claims, they will pay these assessments directly to the Department of Industrial Relations. The State asserts collecting these assessments provides a stable source of funding to support operations of the

courts, ensure safe and health working conditions for California employees and to enforce labor standards and requirements for workers' compensation coverage.

These assessments are listed below:

- Workers' Compensation Administration Revolving Fund Assessment (WCARF)
- Subsequent Injuries Benefits Trust Fund Assessment (SIBTF)
- Uninsured Employers Benefits Trust Fund Assessment (UEBTF)
- Occupational Safety and Health Fund Assessment (OSHF)
- Labor Enforcement and Compliance Fund Assessment (LECF)
- Workers' Compensation Fraud Account Assessment (FRAUD)

Self-Insured Employer's Annual Responsibilities

A self-insured certificate will be issued to each employer or self-insured group being approved by OSIP to self-insure their workers' compensation losses. Each certificate will contain a certificate number identifying the employer or self-insured group. This certificate number will allow OSIP to track compliance with certain reporting requirements.

Self-Insurer's Annual Report

Each certificate to self-insure must have a corresponding annual report filed each year. The Chief of OSIP is required to post the Annual Report form on the department's website 60 days prior to the report becoming due. The annual report for each self-insured certificate must be filed using the OSIP's online platform.

Individual Private and Private Group Self-Insurers

This group uses Form AR-1 (1-2016) to file their annual report. The report is due on or before March 1st of each year. The report is to cover liabilities during the January 1st through December 31st fiscal year.

Public Self-Insurers Including Joint Powers Authority

This group uses Form AR-2 (1-2020) to file their annual report. The report is due on or before October 1 of each year. The report is to cover liabilities during the July 1 through June 30 fiscal year.

Annual Reports Contents

At a high level the annual report serves as a snapshot to OSIP on the number of open claims, amounts paid and funds outstanding. The form required for private self-insurers differs slightly from the form required for public entities. Below is a list of each section.

- General Information
- Claims Liability and Administrator Information
- Open Indemnity Claims Information
- Specific Excess Coverage Calculation
- Company Officer Certification Information

Consequences for Filing the Annual Report Late or Neglecting to File
The OSIP Chief may assess a civil penalty against any self-insurer that fails to file a complete and timely self-insurer's annual report. If the employer could face revocation of their certificate if they continue to fail in filing the report after receiving a civil penalty.

The Chief could provide the employer with additional time to file their annual report without assessing a civil penalty.

Requirement for Private Self-Insurers to File an Annual Actuarial Study
All private self-insurers including self-insured groups must submit an actuarial study and an actuarial summary by May 1st of each year using a valuation date of December 31st of the previous year.

Per Regulation § 15209, the actuarial study must identify the self-insurer's losses at the undiscounted "expected level" or also referred to as the undiscounted "actuarial central estimate" and include each of the below components:

- Incurred but not reported liabilities (IBNR);
- Allocated loss adjustment expenses (ALAE);
- Unallocated loss adjustment expenses (ULAE); and
- Case reserves.

The actuarial central estimate shall be reported at both the gross and net amounts of excess insurance values.

Private and group self-insured groups are not required to file an annual actuarial analysis with OSIP if:

- Their most recently filed self-insurer's annual report had:
    - 10 or fewer open claims, or
    - Less than $1,000,000 of total estimated future liabilities.

The Chief could revoke the self-insurer's certificate for failure to file the required actuarial study and summary.

Public entities are not required to file an annual actuarial study.

Security Deposits by Private Self-Insurers Includes Self Insured Groups
It is important to note that public self-insured entities are not required to post or maintain a security deposit with the Director for workers' compensation liabilities.

Regulation §15210 outlines the requirements for private self-insurers including self-insured groups when posting their security deposit.

Individual private self-insurers are required to post and maintain a security deposit.

At a minimum, the required security deposit must be equal to the self-insurer's losses are an undiscounted "expected level" also referred to as the undiscounted "actuarial central estimate", including the below components:

- incurred but not reported (IBNR) liabilities,
- Allocated loss adjustment expense (ALAE), and
- Unallocated loss adjusted expense (ULAE),
- net of specific excess insurance coverage.

The required deposit may be increased at the Director's.

For any new private self-insurers, the security deposit must in an amount equal to or greater of the following:

- Sixty percent (60%) of the one-year average incurred liability calculated by averaging the prior three years' incurred liability; or
- An amount equal to the self-insurer's projected losses, net of specific excess insurance coverage, if any, and inclusive of incurred but not reported (IBNR) liabilities, allocated loss adjustment expense, and unallocated loss adjustment expense, calculated as of December 31 of each year as prepared by a qualified actuarial.
- A higher amount approved by the Director.

Acceptable Methods for the Security Deposit

Below are the acceptable methods to post the required security deposit.

- A surety bond executed on State issued bond and rider forms;
- An irrevocable letter of credit issued by a bank or savings institution or other financial institution;
- Approved securities in the form of government issued or corporate issued securities;
- Cash in trust; or
- Any combination of one or more of the above four types of security deposit.

Adjustments to the Security Deposit

The Chief must review at least annually the security deposit requirement for each private self-insured employer.

The individual private self-insurer must post any annual increase or decrease in security deposit indicated in the annual actuarial study and summary or as determined by the Chief due:

- to an audit,
- change in the self-insured employer's program; or
- based on a change in the required deposit made by the Chief.

This deposit posting is due no later than 30 days from the date the written notice of security deposit demand is made.

The Chief may provide written authorization to decrease the security deposit upon annual review of all required reporting provided by the private self-insurer.

Upon the Chief showing good cause, they may require the individual private self-insurer to post and maintain an additional security deposit or adjust the required security deposit for a specific

private self-insurer above the actuarially determined expected losses. Good cause includes, but is not limited to:

- understated future liability of claims on the Self-Insurer's Annual Report;
- the lack of, or an inadequate or unacceptable, actuarial study or summary;
- a pattern of understated liabilities in claim files audited in an audit;
- failure to report all claims;
- poor administration of claims or payment of benefits due injured workers found in an audit;
- lack of an effective safety and health program;
- impairment of financial condition of the self-insurer as determined by the Chief; or
- failure to provide and maintain current and complete parental Guaranty of Workers' Compensation Liabilities or board of director's resolutions.

Claim File Contents
Regulation § 15400 itemizes what OSIP requires be contained in the claims file.

Below is an outline of these requirements.

- 5020 - Employers Report of Occupational Injury or Illness;
- Every report made to the Administrative Director of the Division of Industrial Accidents;
- If applicable a copy of any denial letter;
- 5021 - Doctor's First Report of Occupational Injury or Illness;
- All medical reports, including medical-legal reports;
- All applicable orders of the Workers' Compensation Appeals Board and reports relating thereto;
- Benefit payment history
- All benefit notices

For injuries reported on or after January 1, 2006, each self-administering self-insurer and claims administrator must maintain a claim file for each indemnity and medical-only claim, including denied claims, and shall ensure that each file is complete and current for each claim.

Contents of claim files can be in hard copy, in electronic form, or some combination of hard copy and electronic form.

Files maintained in hard copy shall be in chronological order with the most recently dated documents on top, or subdivided into sections such as medical reports, benefit notices, correspondence, claim notes, and vocational rehabilitation.
Each indemnity file shall contain itemized written documentation showing the basis for the calculation of estimated future liability and for each change in estimated future liability for the claim.

Files or portions of files maintained in electronic form shall be easily retrievable.

Claim Log
Regulation § 15400.1 outlines what is required by the claim administrator concerning maintaining a claim log. This regulation outlines that every self-insurer or its administrative agency shall maintain:

- A manually prepared log of all work injury claims for each self-insurer at each adjusting location; or
- A computerized log of claims for each self-insurer at each adjusting location.

The log must be maintained at the employer's location, or it claim administrator's location. It must be kept current and include all claims reported to the adjusting location.

Maintenance of Records
Regulation § 15400.2 provides requirements for the maintenance of records dealing with self-insured claims. The regulation states:

- All claim files must be kept and maintained for a period of five years from the date of injury or from the date on which the last provision of compensation benefits occurred, whichever is later.

- Claim files with awards for future benefits cannot be destroyed, but two years after the date of the last provision of workers' compensation benefits, they may be converted to an inactive or closed status by the administrator, but only if there is no reasonable expectation that future benefits will be claimed or provided.

- Inactive and closed claim files may be microfilmed or electronically stored for storage. However, if the file is not microfilmed or electronically stored the original paper files shall be maintained for at least two years after the claim has been closed or become inactive. Such microfilmed or electronically stored files must be readily reproducible into legible paper form if requested by the Manager for an audit.

- All claim files and the claim logs shall be kept and maintained in California unless the Manager has given written approval to a self-insurer or former self insurer to administer its workers' compensation self-insurance plan from a location outside of California.

- All claim files and claim logs, together with records of all compensation benefit payments, shall be readily available for inspection by the Manager or his representative.

Certificate to Administer Self-Insured Claims
Regulation § 15450 outlines that each claims administrator must have and possess a valid certificate to administer self-insured claims issued by OSIP.

Each adjusting location must pay an annual fee by June 1st. The first adjusting location must pay $1,000.00 with each subsequent adjusting location paying $200.00 annually. Fees can be paid for up to three years.

Administrator Competence
Regulation § 15452 outlines the requirements of both the administrator and examiner in demonstrating the ability to adjust self-insured claims. It states the below:

- Each self-insurer or third-party claim administrator must conduct the administration of each self-insurance program through the services of a competent person, or persons located in California.

- EXCEPTION1: Upon a showing of good cause, the Manager may authorize administration from locations outside California by an administrator with staff who has demonstrated individual competence.

- The desire to consolidate claims from other states in one location or the desire to reduce expenses related to utilizing a third-party administrator are not good cause for out-of-state administration. The demonstration of individual competence of an out-of-state administrator is not in itself a good cause for out-of-state administration.

- Exception2: The Manager shall not authorize claims administration outside of the State of California for any private group self-insurer.

- Any person may demonstrate individual competence as an administrator for a self-administered self-insurer or an agency administered self-insurance program by successfully passing the written examination designed to test technical knowledge of workers' compensation law and claims administration.

- Each adjusting location of a third-party administrator, or a self-administered self-insurer shall have at least one person who has passed the self-insurance administrator's examination.

- All workers' compensation self-insurance claims at such reporting locations shall be administered and adjusted under the direct supervision of a person who has passed the self-insurance administrator's examination.

- Supervision of claims decisions, setting of estimates of future liability of claims, and proper payment of benefits to injured workers shall be made or reviewed by a person who has passed the self-insurance administrator's examination.

- Lack of competent administrators at any adjusting location shall be good cause for revocation of the certificate to administer for that location and may be grounds to revoke the certificate to self-insure.

Reserving Self-Insured Claims

So, why is accurate reserving so critical for self-insured employers. First and foremost, California self-insured employers are required to provide the Office of Self Insurance Plans with an annual independent actuarial analysis that determines the ultimate exposure of the self-insurer's workers compensation liabilities.

Per Labor Code Section §3710(c), the collateral deposit paid by the self-insured employer shall be an amount equal to the self-insurer's projected losses, net of specific excess insurance coverage and inclusive of incurred but not reported (IBNR) liabilities and unallocated loss adjustment expenses, calculated as of December 31st of each year.

The Office of Self Insurance routinely audits self-insureds. The first phase of an audit consists of the auditor conducting a "desk review" of the actuarial report and summary of past audit

findings. If the auditor is not satisfied reserving practices are sound the audit will progress to the second phase in which files and reserves are analyzed.

Additionally, if reserves do not accurately project losses, the collateral amount owed each year will consistently increase.

In 2006, Article 6 "Estimating Work Injury Claims and Medical Reports" was adopted and placed in Title 8 of the California Code of Regulations. This article provided specific guidance on how claim administrators were required to reserve self-insured claims. Below is a brief description of the various sections of Regulation §15300.

- **Set Realistic Future Liabilities:** The administrator shall set a "realistic" reserve of future liability on each claim listed on the self-insured's annual report.

- **Set Reserves Based on Probable Cost Expected Over the Life of the Claim:** A realistic reserve must be sufficient to cover the "probable total future costs" of compensation and medical benefits that can be reasonably expected to be due over the life of the claim. This can get tricky when it can be expected early on the employee will be found entitled to lifetime medical care.

- **Reserves Based on Information Contained in the Claim File:** The reserve must be based on
  information in the claim file at the end of the period of time covered by the annual report.

- **Timing of Reserve Adjustments**: The administrator is required to adjust the reserve immediately upon the receipt of medical reports, orders or other relevant information that impacts the valuation of the claim. Each reserve must be reviewed no less than annually and prior to the filing of the Self Insurer's Annual Report.

- **Medical and Indemnity Reserves Itemized Separately:** Each estimate of future liability shall separately reflect an indemnity and medical component.
  - The indemnity section shall include the estimated future cost of all temporary/permanent disability, death benefits including burial costs and the supplemental job displacement benefit.
  - The medical section shall include the estimated future cost of all medical treatment.
    - In 2012, certain medical cost containment fees were carved out of the medical reserve and instead considered unallocated loss adjustment expenses.
- **132(a), Serious and Willful Misconduct and Penalties:** Reserves must include reasonably expected costs related to Labor Code Section §132(a), Labor Code Section §4553 regarding Serious and Willful Misconduct and penalties per Labor Code Section §5814 resulting from an unreasonable delay in paying benefits.

- **Permanent Disability and Conflicting Medical Reports:** In estimating a permanent disability reserve where conflicting permanent disability ratings exist, the reserve shall

be based on the higher rating, unless there is sufficient evidence in the claim file to support the lower rating.

- **Estimating Medical Costs, Employee is not MMI:** In setting a medical reserve in a case in which the employee is not yet MMI, the reserve must reflect the anticipated medical costs for the life of the claim. This can be challenging when it is anticipated early on the employee will be entitled to medical care for their lifetime.

- **Estimating Medical Costs, Employee is MMI:** When the employee is MMI, medical costs must be estimated based on the average medical costs over the past three years since the employee was declared MMI, or lesser period if three years has not passed. This average annual medical cost is multiplied by the employee's life expectancy per the life expectancy chart listed in the "Forms" section on the Office of Self Insurance Plans website. This estimate must also include the costs of medical care, for example surgeries, which can reasonably be expected over the life of the claim.

- **Reduction in Estimated Costs:**
    - **Documentation that Future Treatment will Not Occur:** Medical reserves based on average past costs can be reduced for treatment not reasonably expected to occur backed by medical documentation contained in the file. Reductions based on anticipated decreases in treatment frequency, the examiner's prior experience, educated guesses and/or conjecture are not permitted.
    - **Decreases in Official Medical Fee Schedule:** Reserves based on past costs can be reduced if a reduction is made in the official medical fee schedule for the relevant anticipated future medical treatment.
    - **Uncontested Utilization Review:** Reserves based on past costs can be reduced based on utilization review, unless the utilization review decision was successfully contested.
    - **Order Allowing Credit for Third Party Recovery:** The only time reserves can be reduced based on subrogation is when the file contains an approved order from the Workers' Compensation Appeals Board allowing for credit based on the third-party recovery.
    - **Permanent Disability and Apportionment:** Reserves for permanent disability can only be reduced based on apportionment when the file contains the needed evidence that justifies this decrease.

- **Present Value:** Reserves shall not be reduced to reflect the present value of future benefits.

- **Excess Recovery:** Estimates of future liability shall not be decreased based on projected reimbursements from aggregate excess insurance reimbursements.

Office of Self-Insurance Plans Audits

The California Office of Self Insurance Plans is tasked with ensuring reserves set on self-insured files are adequate and set based on California regulations guiding how self-insured files must be reserved.

An employer or group that desires to self-insured payment of workers' compensation benefits must apply for approval from the State. Upon the State approving, the employer or group will be provided with a certificate to self-insure.

Office of Self-Insurance Plans is tasked with auditing each certificate once every five years.

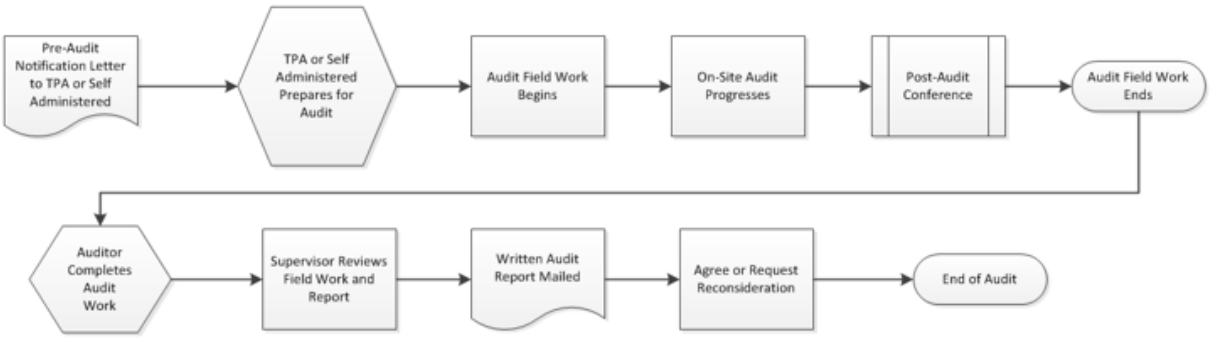
OSIP Audits are comprised of two phases. Passing the first phase ends the audit.

Phase I

Desk Audit

Phase II

Field Audit



The 10 Most Common Issues Identified During an OSIP Audit

1. Not identifying all issues on a claim and the associated probable future cost, indemnity and/or medical, over the life of the claim based on the facts of the case. 8CCR§15300
2. Failing to annually review medical treatment costs and reserve adequacy when the injured worker has a lifetime medical award. Not adjusting reserves upon receipt of relevant information that affects the valuation of the claim. 8CCR§15300(g)
3. For MMI/P&S status claims – Not adjusting reserves to reflect the average annual medical treatment costs based on the past three years (or less if it has been less than three years since the injured worker has reached an MMI/P&S status). 8CCR§15300(b)(4)
4. For non MMI/P&S claims – Not reserving for the life of the claim. 8CCR§15300(b)(3)
5. Using the wrong life expectancy table when calculating estimates of future liability. 8CCR§15300(b)(7), 8CCR§15300(b)(9)
6. Failing to reserve for the higher permanent disability rating unless there is sufficient factual evidence to support a lower rating. 8CCR§15300(b)(2) and lowering permanent disability due to apportionment without basis or facts to support it, 8CCR§15300(b)(8)
7. Inaccurately reporting excess insurance information.
8. Allowing the self-insured employer to control estimates of future liability. 8CCR§15452
9. Failing to determine the outstanding lien and unresolved unpaid medical provider balances and the expected cost of resolution based on the facts of the case. 8CCR§15300(b)(1)
10. Prematurely closing claims with lifetime future medical benefits due. 8CCR§15400.2(a)

PART EIGHT | 132(A) – SERIOUS & WILLFUL MISCONDUCT

Labor Code § 132(a)

Any award because of the employee asserting an action under 132(a) is an uninsurable risk. What this means is an employer cannot secure workers' compensation coverage that will pay in the event a valid 132(a) claim is found and awarded. However, in the event of an employer being self-insured for workers' compensation, they may choose to handle 132(a) assertions from the workers' compensation claim.

Must Verify Legal Defense with Employer
If the examiner receives a petition for a 132(a) claim, they must immediately advise the employer and discuss whether the employer wants to bifurcate the 132(a) from the workers' compensation claim. This would include hiring separate counsel to defend the discrimination claim, paying for this representation from another source including paying any settlement or award regarding the 132(a) claim from another source.

What is a 132(a) claim?
This claim can be asserted when the employee can demonstrate they were discriminated against regarding filing a claim or securing benefits because of the claim.

Consequences of a Valid 132(a) Claim
Below are the consequences of a valid 132(a) claim.

- The employer is found guilty of a misdemeanor
- The employee's compensation is increased by one-half not to exceed $10,000.00
- Reimbursement to the employee of costs and expenses not to exceed $250.00
- Employee will receive reinstatement and reimbursement of lost wages and work benefits

Labor Code § 132(a) states:

> ***"Any employer who discharges, or threatens to discharge, or in any manner discriminates against any employee because he or she has filed or made known his or her intention to file a claim for compensation with his or her employer or an application for adjudication, or because the employee has received a rating, award, or settlement, is guilty of a misdemeanor and the employee's compensation shall be increased by one-half, but in no event more than ten thousand dollars ($10,000), together with costs and expenses not in excess of two hundred fifty dollars ($250). Any such employee shall also be entitled to reinstatement and reimbursement for lost wages and work benefits caused by the acts of the employer."***

Serious & Willful Misconduct

Assertions of S&W can be claimed by either the employee or the employer.

Valid findings of a S&W violation result in compensation being increased or decreased by 50%.

If the employee is asserting a S&W violation, they have the burden of proof.

The test of a valid finding of S&W misconduct on the behalf of the employer is demonstrating:

- Intentional knowledge of wrongdoing
- Extreme disregard for the employee's safety
- Employer's intentional or extraordinary harmful actions or inactions

PART NINE | MEDICAL-LEGAL EVALUATIONS

A Dispute Must Exist

Labor Code Section 4060/4061/4062

- AOE/COE & only used when nothing has been accepted as compensable
  - Labor Code Section 4060
- This code is used to dispute the level of permanent disability
  - Labor Code Section 4061
- This section is reserved for disputes not covered in 4060 or 4061.
  - Labor Code Section 4062

Denial Categories

Not all claim disputes require a medical-legal evaluation. Medical legal evaluations should be reserved to resolve disputed medical facts. Below is a list of the different types of disputes that could lead to a denial of claim.

Medical

A physician concludes that the claimed injury cannot be related to the work event.

For example – The employee claims a rotator cuff tear from being involved in an auto accident.

Legal

The assertion made by the employee, or their representative is not allowed under the Labor Code.

For example – The employee asserts a specific injury two years after the event.

Factual

A discrepancy exists between how the employee states the injury occurred and statements of witnesses, co-workers and managers.

For example – The employee states they slipped and fell but several co-workers state it did not happen.

Contested Claim
Below are examples of what would constitute a contested claim that may require a medical-legal evaluation.

- ***Rejected liability*** for a claimed benefit.
- ***Failed to accept liability*** for a claim and the claim has become presumptively compensable.
- Where the claims administrator has ***failed to respond to a demand*** for the payment of compensation after the expiration of any time period fixed by statute for the payment of indemnity benefits.
- Where the claims administrator has accepted liability for a claim and a ***disputed medical fact exists.***

Disputed Medical Fact
An issue in dispute, including an objection to a medical determination made by a treating physician concerning:

- the employee's ***medical condition***
- the cause of the employee's ***medical condition***, or
- the existence, nature, duration or extent of temporary or permanent disability caused by the employee's ***medical condition***.

A Comprehensive Medical-Legal Evaluation
An evaluation, which includes an examination of an employee which results in the preparation of a narrative medical report and is either:

- Performed by a Qualified Medical Evaluator, or
- Performed by an Agreed Medical Evaluator, or the primary treating physician for the purpose of ***proving or disproving a contested claim.***

Labor Code § 4050 & 4053
Labor Code Section 4050 allows the employer to obtain an evaluation from a practicing physician at any time at the employer's expense.
These reports are inadmissible, so when is 4050 useful?

- Help prepare an attorney to cross-ex the QME or AME
- Provide the treating physician with a compelling opinion
- Assist in providing medical evidence regarding AOE/COE
- Solidify a misrepresentation made by the injured worker

Labor Code Section 4053 states that the failure of an employee to show for this evaluation could lead to the suspension of benefits.

Medical Legal Evaluation Requirements

- The report is prepared by a physician.
- The report is obtained for the purpose of ***proving or disproving a contested claim.***
- Addresses the ***disputed medical fact or facts*****.**
- Nothing prohibits a physician from addressing additional related medical issues.

- The report is capable of proving or disproving ***a disputed medical fact*** essential to the resolution of a contested claim.
- The medical-legal examination is performed prior to receipt of notice that the disputed medical fact(s) for which the report was requested have been resolved.

Substantial Medical Evidence
A medical-legal report must contain specific information to be considered substantial medical evidence. These elements are listed below.

Date of the Examination	History of the Patient	Patient's Complaints
Listing of all Information Received	Findings on Examination	Findings of Examination
Patient's Medical History	Cause of Disability	Diagnosis
Disability & Work Limitations	Apportionment Determination	Future Medical Care Needs
MMI Status & Extent of PD	Signature of the Physician	Percentage of Causation (psyche)
Reasons for the Opinion	History of Injury	

Medical-Legal Fees

Missed Appointment
ML CODE 200 RV 31 - $503.75

Comprehensive Medical-Legal Evaluation
ML CODE 201 RV 124 - $2,015.00

Follow Up Medical-Legal Evaluation
ML CODE 202 RV 81 - $1,316.25

Supplemental Medical-Legal Evaluation
ML CODE 203 RV 40 - $650.00

Review of Sub Rosa
ML CODE 205 RV 5 - $325/hr

Medical-Legal Testimony
ML CODE 204 RV 7 - $455/hr

Records Review
MLPRR - $3.00 per page over 200 pages

PART TEN | LITIGATION

An injured employee may feel it necessary to secure the services of an attorney to represent them for their workers' compensation claim. This section provides a high-level summary of the some the salient issues and requirements when encountering litigation.

Disclosure Statement and Contingency Fee Agreement
In the event the employee determines they require the assistance of an attorney, the applicant's attorney must disclose their fee with the employee agreeing and signing.

The State provides guidance on what is required with DWC Form 3.

This form notifies the employee of the following:

- Fees are deducted from the injured employee's benefits.
- The fee must be approved by the Workers' Compensation Appeals Board (WCAB)
    - When evaluating the fee, the WCAB must consider the following
        - Responsibility assumed by the attorney
        - Care exercised in representing in the injured worker
        - Time involved
        - Results obtained
- Circumstances in which the employer may be liable for their attorney's fee
- The employee can withdraw from representation
- The venue location
- How to contact an Information and Assistance Officer
- Statement regarding fraud

Application for Adjudication of Claim
The Application for Adjudication of Claim or DWC Form 1A sets jurisdiction with the Workers' Compensation Appeals Board. The WCAB will respond by providing the ADJ Number which must be used going forward on all correspondence with the Board.

This form contains the following sections:

- Establishes venue based on three factors
    - County of the employee's residence
    - County where the injury occurred
    - County of principal place of business of employee's attorney
- Injured Worker Information
- Applicant Information (if other than the employee)
    - Carrier
    - Employer
    - Lien Claimant
- Employer Information
- Carrier Information
- Claims Administrator Information
- Details of the Injury
    - Occupation
    - Specific or Cumulative Injury
    - Location of Injury

- Body Parts Injured
- How the Injury Occurred
- Earning at Time of Injury
- Disability Caused by the Injury
- Benefits Paid
- Confirmation if the Employee received State Disability Benefits
- Medical Treatment Received
- Confirmation if Med-Cal Paid for Medical Benefits
- Names and Addresses if Physician that Treated the Injury
- Other Cases Filed with the WCAB
- Disagreement or Dispute Causing the Need to File the Application
- Confirmation the Employee is Represented and Firm's Information
- Signature of Employee and Attorney

Answer to the Application for Adjudication of Claim
The Answer allows the other party to affirm and add additional information and disputes regarding the Application filed.

DWC Form 10 is three pages and provides the below sections.

- Case/ADJ Number
- Type of Injury – Specific/Cumulative
- Injured Worker Information
- Employer Information
- Carrier Information
- Claims Administrator Information
- Defendants Ability to Deny Allegations Made on the Application
    - Employment
    - Occupation
    - Injury
    - Coverage
    - Liability for Self-Procured Treatment
    - Liability for Future Medical Care
    - Medical Legal Costs
    - Earning
    - Periods of Disability
    - Voucher
    - Permanent Disability

When is the Employer Responsible for Applicant's Attorney Fees
Below are some reasons in which the employer will be responsible for the Applicant's fees

- Employer's unreasonable delay or refusal to pay benefits
- Deposition Fees allowed under Labor Code § 5710
- Employer Filing an Application for Adjudication of Claim

Depositions
Labor Code § 5710 provides some guidance regarding taking depositions in a workers' compensation case.

The appeals board, a workers' compensation judge, or any party to the action or proceeding, may, in any investigation or hearing before the appeals board, cause the deposition of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil actions in the superior courts.

Attendance of witnesses and the production of records may be required.

WCAB Judge will approve the fee recommended by the Applicant's Attorney. This hourly fee can vary based on the Attorney's years of experience.

Labor Code § 5710 provides some guidance regarding taking depositions in a workers' compensation case.

If the employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits as a dependent of an injured employee, the deponent is entitled to receive in addition to all other benefits:

- All reasonable expenses of transportation, meals, and lodging incident to the deposition.
- Reimbursement for any loss of wages incurred during attendance at the deposition.
- One copy of the transcript of the deposition, without cost.
- A reasonable allowance for attorney's fees for the deponent, if represented by an attorney licensed by the State Bar of this state. The fee shall be discretionary with, and, if allowed, shall be set by, the appeals board, but shall be paid by the employer or his or her insurer.
- If interpretation services are required because the injured employee or deponent does not proficiently speak or understand the English language, upon a request from either, the employer shall pay for the services of a language interpreter certified or deemed certified pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code. The fee to be paid by the employer shall be in accordance with the fee schedule adopted by the administrative director and shall include any other deposition-related events as permitted by the administrative director.

Hearings

Mandatory Settlement Conferences
Typically, the first hearing is in the workers' compensation process. This hearing allows the parties to discuss disputed issues and if necessary, set the case for trial.

Priority Conference
This hearing is utilized concerning AOE/COE only

Expedited Hearing
This is utilized when disputes exist concerning medical treatment or temporary disability.

Informal Conference
This hearing is just like it is named and used for the parties to informally discuss issues and resolution.

Emergency Hearing
When the issue at hand is time sensitive.

Pre-Formal Hearing
To discuss issues that cannot be resolved informally.

Formal Hearing
This is scheduled with informal and pre-formal hearing cannot resolve the issue.

PART ELEVEN | SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

Supplemental Job Displacement Voucher was established to replace Vocational Rehabilitation benefits and provide funds to injured workers that cannot return to work with their employer and/or the employer failed to timely offer a suitable job to the employee.

Below are the criteria for entitlement to the voucher:

- The injury must result in permanent impairment.
- The employer does not offer other regular, modified, or alternative work.
- The job offered must pay at least 85% of the worker's earnings at the time of the injury and will be expected to last for 12 months.
- The work offer is due within 60 days after the claim administrator receiving the physician's return to work & voucher report (Form DWC-AD 10133.36).
- If an offer of work cannot or was not made timely, within 20 days of the 60 days expiring, the claim administrator must provide the employee with a voucher.

Expiration of the Voucher

The voucher will expire within two years of being issued or five years from the date of injury, whichever comes later.

Voucher Amount

The voucher amount is $6000 for all levels of permanent disability and can be used for training at a California public school or any other provider listed on the state's eligible training provider list.

It can also be used to pay licensing or certification and testing fees, to purchase tools required by a training course.

- Up to $1,000 can be used purchase computer equipment
- Up to $500 can be used in miscellaneous expenses.
- Up to 10 percent, or $600, may be used to pay for the services of a licensed placement agency or vocational counselor.

PART TWELVE | RESOLUTION

Stipulation with Request for Award

The stipulation will memorialize benefit amounts and levels concerning temporary disability and permanent impairment.

The agreement will state whether the employee is entitled to future medical care. Interest is owed on all awards unless language waives this requirement. Stipulations are payable within 20 days of approval.

Stipulations are paid every two weeks until the award is paid in full. When in receipt of an approved stipulation, the examiner should check and pay any retroactive payments needed from the last date of TTD paid or the MMI date whichever is earlier.

Commutation

If the employee can demonstrate a hardship and need for the Stipulation to be in one lump sum they can ask for a commutation.

The administrative law judge will need to review the request and if granted, the administrator will need to complete a commutation to determine the lump sum owed.

Commutations will discount the lump sum for interest that would have been earned over time if the award was not paid in full.

Compromise and Release

A compromise and Release agreements memorialize all benefits paid and any benefits that are still owed. This includes any medical care costs that are outstanding and who is the responsible party.

The C&R will document an amount of money to resolve all aspects of the case. It will itemize out of this amount what has already been paid and what is owed.

Interest is due on a C&R agreement unless it is waived by language.

The parties can specify the number of days the C&R must be paid but traditionally they are owed within 30 days of approval.

A compromise and release agreement is paid in one lump sum.

Findings and Award

An F&A usually comes about because of going to trial or a hearing in which the Judge must issue an Award. Interest is payable from the date of the award at the same rate as civil judgements.

APPENDIX

Commonly Used Acronyms

Indemnity Benefits

4850 Benefits	LC 4850 Benefits for Police Officers and Fire Fighters
AMA Guides	American Medical Association Guides for Evaluating Permanent Impairment, 5th Edition
AWW	Average Weekly Wage
COLA	Cost of Living Adjustment
DB	Death Benefit
EDD	Employment Development Dept
LP	Life Pension
MMI	Maximum Medical Improvement
P&S	Permanent & Stationary
PD	Permanent Disability
PDA	Permanent Disability Advance
PDR	Permanent Disability Rating
PDRS	Permanent Disability Rating Schedule
PPD	Permanent Partial Disability
PTD	Permanent Total Disability
SAWW	State Average Weekly Wage
SC	Salary Continuation
TD	Temporary Disability
TPD	Temporary Partial Disability
TTD	Temporary Total Disability
WL	Wage Loss
WS	Wage Statement
WPI	Whole Person Impairment Rating
ROM	Range of Motion
DRE	Diagnosis Related Evaluation
IR	Impairment Rating
IDL	Industrial Disability Leave

Medical Benefits

PR-2	Primary Treating Physicians Progress Report
5021	Doctor's First Report of Injury
SX	Surgery
TX	Treatment
PR-3	Primary Treating Physicians Permanent & Stationary Report Used for Permanent Disability Ratings to the 1997 Rating Schedule
PR-4	Primary Treating Physician Permanent & Stationary Report Used for Permanent Disability Ratings to the 2005 Rating Schedule
PRN	Follow Up with the Physician as Needed

Commonly Used Acronyms

Medical Benefits

HCO	Health Care Organization
MPN	Medical Provider Network
PTP	Primary Treating Physicians
DX	Diagnosis
IBR	Independent Bill Review
SBR	Second Bill Review
UR	Utilization Review
EOB	Explanation of Benefits
OMFS	Official Medical Fee Schedule
OTC	Over the County Medications

Department of Industrial Relations

DIR	Department of Industrial Relations
DWC	Division of Workers' Compensation
A.D.	Administrative Director
OSIP	Office of Self Insurance Plans
CHSWC	Commission on Health and Safety and Workers' Compensation
Cal OSHA	California Occupational Safety and Health Act
DEU	Disability Evaluation Unit
I&A Officer	Information and Assistance Officer
WCAB	Workers' Compensation Appeals Board
CMU	California Medical Unit

Reference and Database

WCIS	Workers' Compensation Information System
EDEX	Electronic Data Exchange System
EAMS	Electronic Adjudication Management System
INDEX	Database of Insurance Claims Reported by Participating Carriers

Stakeholders

A/A	Applicant Attorney
D/A	Defense Attorney
EE	Employee
ER	Employer
IW	Injured Worker
PTP	Primary Treating Physicians
IC	Independent Contractor
TPA	Third Party Administrator

Commonly Used Acronyms

Utilization Review

ACOEM	American College of Occupational and Environmental Medicine
CAMTUS	California Medical Treatment Utilization Schedule
UR	Utilization Review
IMR	Independent Medical Review

Return to Work

ADA	American with Disabilities Act
EEOC	Equal Employment Opportunity Commission
VRTWC	Vocational & Return to Work Counselor
RRTW	Return to Regular Work
RTW	Return to Work
SJDB	Supplemental Job Displacement Benefit
JA	Job Analysis
JD	Job Description
STD	Short Term Disability
LTD	Long Term Disability
LDW	Last Day Worked
SDI	State Disability Insurance
SSDI	Social Security Disability Indemnity
SSD	Social Security Disability
U&C	Usual and Customary Duty
FCE	Functional Capacity Evaluation
FEC	Future Earning Capacity
FEHA	California Fair Employment and Housing Act
FMLA	Family Medical Leave Act

Medical-Legal Evaluations

AME	Agreed Medical Evaluator
QME	Qualified Medical Evaluator
IME	Independent Medical Evaluator
Med-Legal	Medical-Legal Examination by a QME, AME, PTP or IME
CME	Comprehensive Medical Evaluation

Common Claim Acronyms

AOE/COE	Arising and Out and in the Course of Employment
CT	Continuous Trauma Injury
DOI	Date of Injury
DOL	Date of Loss
DWC-1	Claim Form DWC-1 & Notice of Potential Eligibility

Commonly Used Acronyms

Common Claim Acronyms

5020	Employers First Report of Injury

Medicare Set Aside

MSA	Medicare Set Aside
CMS	Center for Medicare and Medicaid Services
COB	Coordination of Benefits
MIR	Mandatory Insurer Reporting
MSP	Medicare Secondary Payer
MSPRP	Medicare Secondary Payer Recovery Portal
ORM	Ongoing Responsibility for Medicals
SSDI	Social Security Disability Indemnity
RRE	Responsible Reporting Entity
TPOC	Total Payment Obligation to the Claimant

Case Resolution

C&R	Compromise and Release Agreement
F&A	Findings and Award
OACR	Order Approving C&R
Stip	Stipulation with Request for Award

Workers' Compensation Appeals Board

D&O	Determination & Order
PJ	Presiding Judge
ALJ	Administrative Law Judge
MSC	Mandatory Settlement Conference
OTOC	Order Taking Off Calendar
DCA	District Court of Appeal

Miscellaneous

E&O	Errors and Omissions
EDC	Education Code
LC	Labor Code
PSI	Permissibly Self-Insured
S&W	Serious & Willful
SIF	Subsequent Injuries Fund
SII	Self Imposed Increase
SIU	Special Investigation Unit
SOL	Statute of Limitations
SSA	Social Security Administration

Commonly Used Acronyms

Miscellaneous

UEF	Uninsured Employers Fund
CIGA	California Insurance Guarantee Association
Depo	Deposition
DOR	Declaration of Readiness to Proceed

Glossary of workers' compensation terms for injured workers

Accepted claim: A claim in which the insurance company agrees your injury or illness is covered by workers' compensation. Even if your claim is accepted there may be delays or other problems. Also called admitted claim.

Administrative director (AD): The person who is in charge of the operation of the Division of Workers' Compensation.

Agreed medical evaluator (AME): If you have an attorney, an AME is the doctor your attorney and the insurance company agree on to conduct the medical examination that will help resolve your dispute. If you don't have an attorney, you will use a qualified medical evaluator (QME). See QME.

Alternative work: A new job with your former employer. If your doctor says you will not be able to return to your job at the time of injury, your employer is encouraged to offer you alternative work instead of supplemental job displacement benefits or vocational rehabilitation benefits. The alternative work must meet your work restrictions, last at least 12 months, pay at least 85 percent of the wages and benefits you were paid at the time you were injured, and be within a reasonable commuting distance of where you lived at the time of injury.

American Medical Association (AMA): A national physician's group. The AMA publishes a set of guidelines called "Guides to the Evaluation of Permanent Impairment." If your permanent disability is rated under the 2005 rating schedule, the doctor is required to determine your level of impairment using the AMA's guides.

Americans with Disabilities Act (ADA): A federal law that prohibits discrimination against people with disabilities. If you believe you've been discriminated against at work because you're disabled and want information on your rights under the ADA, contact a U.S. Equal Employment Opportunity Commission office. For the EEOC office in your area, call 1-800-669-4000 or 1-800-669-6820 (TTY).

AOE/COE (Arising out of and occurring in the course of employment): Your injury must be caused by and happen on the job.

Appeals board: A group of seven commissioners appointed by the governor to review and reconsider decisions of workers' compensation administrative law judges. Also called the Reconsideration Unit. See Workers' Compensation Appeals Board**.**

Applicant: The party -- usually you -- that opens a case at the local Workers' Compensation Appeals Board (WCAB) office by filing an application for adjudication of claim*.*

Applicants' attorney: A lawyer that can represent you in your workers' compensation case. Applicant refers to you, the injured worker.

Application for adjudication of claim (application or app): A form you file to open a case at the local Workers' Compensation Appeals Board (WCAB) office if you have a disagreement with the insurance company about your claim.

Apportionment: A way of figuring out how much of your permanent disability is due to your work injury and how much is due to other disabilities.

Audit Unit: A unit within the DWC that receives complaints against claims administrators. These complaints may lead to investigations of the way the company handles claims.

Benefit notice: A required letter or form sent to you by the insurance company to inform you of benefits you may be entitled to receive. Also called notice.

Cal/OSHA: A unit within the state Division of Occupational Safety and Health (DOSH). Cal/OSHA inspects workplaces and enforces laws to protect the health and safety of workers in California.

California Labor Code section 132a: A workers' compensation law that prohibits discrimination against you because you filed a workers' compensation claim, and against co-workers who might testify in your case.

Carve-out: Carve-out programs allow employers and unions to create their own alternatives for workers' compensation benefit delivery and dispute resolution under a collective bargaining agreement.

Claim form (DWC-1): The form used to report a work injury or illness to your employer.

Claims adjuster: See claims administrator.

Claims administrator: The term for insurance companies and others that handle your workers' compensation claim. Most claims administrators work for insurance companies or third party administrators handling claims for employers. Some claims administrators work directly for large employers that handle their own claims. Also called claims examiner or claims adjuster.

Claims examiner: See claims administrator.

Commission on Health and Safety and Workers' Compensation (CHSWC): A state-appointed body that conducts studies and makes recommendations to improve the California workers' compensation and workplace health and safety systems.

Commutation: An order by a workers' compensation judge for a lump sum payment of part or all of your permanent disability award.

Compromise and release (C&R): A type of settlement in which you receive a lump sum payment and become responsible for paying for your future medical care. A settlement like this must be approved by a workers' compensation judge.

Cumulative injury (CT): An injury that was caused by repeated events or repeated exposures at work. For example, hurting your wrist doing the same motion over and over or losing your hearing because of constant loud noise.

Date of injury: When you got hurt or ill. If your injury was caused by one event, the date it happened is the date of injury. If the injury or illness was caused by repeated exposures (a cumulative injury), the date of injury is the date you knew or should have known the injury was caused by work.

Death benefits: Benefits paid to surviving dependents when a work injury or illness results in death.

Declaration of readiness (DOR or DR): A form used to request a hearing before a workers' compensation judge when you're ready to resolve a dispute.

Defendant: The party –- usually your employer or its insurance company -- opposing you in a dispute over benefits or services.

Delay letter: A letter sent to you by the insurance company that explains why payments are delayed. The letter also tells you what information is needed before payments will be sent and when a decision will be made about the payments.

Denied claim: A claim in which the insurance company believes your injury or illness is not covered by workers' compensation and has notified you of the decision.

Description of employee's job duties (DWC form # AD 10133.33): A form to be filled out by the employer and employee to describe the employee's job duties. The form will be reviewed by a physician to determine if the employee is able to return to work.

Disability: A physical or mental impairment that limits your life activities. A condition that makes engaging in physical, social and work activities difficult.

Disability Evaluation Unit (DEU): A unit within the DWC that calculates the percent of permanent disability based on medical reports. See disability rater.

Disability management: A process to prevent disability from occurring or to intervene early, following the start of a disability, to encourage and support continued employment. This is done early in the recovery process in severe injury cases such as spinal injuries. Usually a rehabilitation nurse is involved with you and your treating doctor and the progress of your medical treatment is reported to the insurance company.

Disability rater: An employee of the DWC Disability Evaluation Unit who rates your permanent disability after reviewing a medical report or a medical-legal report describing your condition.

Disability rating: See permanent disability rating.

Discrimination claim (Labor Code132a): A petition filed if your employer has fired or otherwise discriminated against you for filing a workers' compensation claim.

Dispute: A disagreement about your right to payments, services or other benefits.

Division of Workers' Compensation (DWC): A division within the state Department of Industrial Relations (DIR). The DWC administers workers' compensation laws, resolves disputes over workers' compensation benefits and provides information and assistance to injured workers and others about the workers' compensation system.

Electronic Adjudication Management System (EAMS): A computer based system to simplify and improve the Division of Workers' Compensation case management process.

Employee: A person whose work activities are under the control of an individual or entity. The term employee includes undocumented workers and minors.

Employer: The person or entity with control over your work activities.

Ergonomics: The study of how to improve the fit between the physical demands of the workplace and the employees who perform the work. That means considering the variability in human capabilities when selecting, designing or modifying equipment, tools, work tasks and the work environment.

Essential functions: Duties considered crucial to the job you want or have. When being considered for alternative work, you must have both the physical and mental qualifications to fulfill the job's essential functions.

Fair Employment and Housing Act (FEHA): A state law that prohibits discrimination against people with disabilities. If you believe you've been discriminated against at work because you're disabled and want more information on your rights under the FEHA, contact the state Department of Fair Employment and Housing at 1-800-884-1684. In some cases, the FEHA provides more protection than the federal Americans with Disabilities Act (ADA).

Family and Medical Leave Act (FMLA): A federal law that provides certain employees with serious health problems or who need to care for a child or other family member with up to 12 weeks of unpaid, job-protected leave per year. It also requires that group health benefits be maintained during the leave. For more information, contact the U.S. Department of Labor at 1-866-4-USA-DOL.

Filing: Sending or delivering a document to an employer or a government agency as part of a legal process. The date of filing is the date the document is received.

Final order: Any order, decision or award made by a workers' compensation judge that has not been appealed in a timely way.

Findings & award (F&A): A written decision by a workers' compensation administrative law judge about your case, including payments and future care that must be provided to you. The F&A becomes a final order unless appealed.

Fraud: Any knowingly false or fraudulent statement for the purpose of obtaining or denying workers' compensation benefits. The penalties for committing fraud are fines up to $150,000 and/or imprisonment for up to five years.

Future medical: On-going right to medical treatment for a work-related injury.

Health care organization (HCO): An organization certified by the Department of Industrial Relations to provide managed medical care within the workers' compensation system.

Hearings: Legal proceedings in which a workers' compensation judge discusses the issues in a case or receives information in order to make a decision about a dispute or a proposed settlement.

Impairment rating: A percentage estimate of how much normal use of your injured body parts you've lost. Impairment ratings are determined based on guidelines published by the American Medical Association (AMA). An impairment rating is used to calculate your permanent disability rating but is different from your permanent disability rating.

In pro per: An injured worker not represented by an attorney.

Independent bill review (IBR): An informal process to resolve billing disputes through an independent third party contracted by DWC.

Independent contractor: There is no set definition of this term. Labor law enforcement agencies and the courts look at several factors when deciding if someone is an employee or an independent contractor. Some employers misclassify employees as an independent contractor to avoid workers' compensation and other payroll responsibilities. Just because an employer says you are an independent contractor and doesn't need to cover you under a workers' compensation policy doesn't make it true. A true independent contractor has control over how their work is done. You probably are <u>not</u> an independent contractor when the person paying you:

- Controls the details or manner of your work
- Has the right to terminate you
- Pays you an hourly wage or salary
- Makes deductions for unemployment or Social Security
- Supplies materials or tools
- Requires you to work specific days or hours

Independent medical review (IMR): An informal process to resolve medical treatment issues through an independent third party contracted by DWC. Only an injured worker can request IMR if their medical treatment request has been denied, modified or delayed.

Independent medical review organization (IMRO): This organization determines if a case is eligible for medical review. If this case is eligible, the organization will notify the parties of pertinent information including whether it is a regular or expedited review and the documents that must be provided to conduct a review.

Information & Assistance (I&A) officer: A DWC employee who answers questions, assists injured workers, provides written materials, conducts informational workshops and holds meetings to informally resolve problems with claims.

Information & Assistance Unit (I&A): A unit within DWC that provides information to all parties in workers' compensation claims and informally resolves disputes.

Injury and illness prevention program (IIPP): A health and safety program employers are required to develop and implement. This program is enforced by Cal/OSHA.

Judge: See workers' compensation administrative law judge.

Lien: A right or claim for payment against a workers' compensation case. A lien claimant, such as a medical provider, can file a form with the local Workers' Compensation Appeals Board to request payment of money owed in a workers' compensation case.

Lien activation fee: A fee required by a lien claimant for liens filed prior to Jan. 1, 2013. This fee must be paid when the DOR is filed, when appearing at a lien conference or by Jan. 1, 2014, otherwise the lien will be dismissed.

Lien filing fee: All liens filed after Jan. 1, 2013 must pay a filing fee for medical treatment related liens.

Mandatory settlement conference (MSC): A required conference to discuss settlement prior to a trial.

Maximal medical improvement (MMI): Your condition is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Once you reach MMI, a doctor can assess how much, if any, permanent disability resulted from your work injury.

Mediation conference: A voluntary conference held before an I&A officer to resolve a dispute if you are not represented by an attorney.

Medical care: See medical treatment.

Medical-legal report: A report written by a doctor that describes your medical condition. These reports are written to help clarify disputed medical issues.

Medical mileage: You are entitled to mileage reimbursement (including parking and tolls) for medical appointments, therapies, pharmacy visits and other medical related travel.

Medical provider network (MPN): An entity or group of health care providers set up by an insurer or self-insured employer and approved by DWC's administrative director to treat workers injured on the job.

Medical treatment: Treatment reasonably required to cure or relieve the effects of a work-related injury or illness. Also called medical care.

Medical Unit: A unit within the DWC that oversees medical provider networks (MPNs), independent medical review (IMR) physicians, health care organizations (HCOs), qualified medical evaluators (QMEs), panel QMEs, utilization review (UR) plans, and spinal surgery second opinion physicians.

Modified work: Your old job, with some changes that allow you do to it. If your doctor says you will not be able to return to your job at the time of injury, your employer is encouraged to offer you modified work instead of supplemental job displacement.

Nontransferable voucher: A document you get from the insurance company that must be completed by both you and the insurance company. This is the document used to provide payment for education under the supplemental job displacement benefit program.

Notice: See benefit notice.

Objective factors: Measurements, direct observations and test results a treating physician, QME or an AME says contribute to your permanent disability.

Off calendar (OTOC): A WCAB case in which there is no pending action.

Offer of modified or alternative work (DWC-AD10133.53): A form you get from the insurance company if: you were injured between Jan. 1 2004 and Dec. 31, 2012 and; your treating physician reports you have a permanent disability and; your employer is offering modified or alternative work instead of a supplemental job displacement benefit. This form also explains how your permanent disability payments may be lowered by 15 percent because your employer is returning you to work.

Offer of regular, modified or alternative work (DWC-AD 10133.35): A form you get from the insurance company if: you were injured on or after Jan. 1, 2013 and; your treating physician reports you have a permanent disability and; your employer is offering regular, modified or alternative work instead of a supplemental job displacement benefit.

Panel qualified medical evaluator (QME): A list of three independent qualified medical evaluators (QMEs) issued by the DWC Medical Unit. You select any one of the three doctors for your evaluation. If you have an attorney, other rules apply.

Party: Normally this includes the insurance company, your employer, attorneys and any other person with an interest in your claim (doctors or hospitals that have not been paid).

Penalty: An amount of money you receive because something wasn't done correctly in your claim. Paid by your employer or the insurance company, the penalty amount can be an automatic 10 percent for a delay in one payment to you, or a 25 percent penalty -- up to $10,000 -- for an unreasonable delay.

Permanent and stationary (P&S): Your medical condition has reached maximum medical improvement. Once you are P&S, a doctor can assess how much, if any, permanent disability resulted from your work injury. If your disability is rated under the 2005 schedule you will see the term maximal medical improvement (MMI) used in place of P&S. See also P&S report.

Permanent disability (PD): Any lasting disability that results in a reduced earning capacity after maximum medical improvement is reached.

Permanent disability advance (PDA): A *voluntary* lump sum payment of permanent disability you are due in the future.

Permanent disability (PD) benefits: Payments you receive when your work injury permanently limits the kinds of work you can do or your ability to earn a living.

Permanent disability payments: A bi-weekly payment based on the undisputed portion of permanent disability received before and/or after an award is issued.

Permanent disability rating (PDR): A percentage that estimates how much a job injury permanently limits the kinds of work you can do. It is based on your medical condition, date of injury, age when injured, occupation when injured, how much of the disability is caused by your job, and your diminished future earning capacity. It determines the number of weeks you are entitled to permanent disability benefits.

Permanent disability rating schedule (PDRS): A DWC publication containing detailed information used to rate permanent disabilities. One of three schedules will be used to rate your disability, depending on when you were injured.

Permanent partial disability award: A final award of permanent partial disability made by a workers' compensation judge or the Workers' Compensation Appeals Board.

Permanent partial disability (PPD) benefits: Payments you receive when your work injury partially limits the kinds of work you can do or your ability to earn a living.

Permanent total disability (PTD) benefits: Payments you receive when you are considered permanently unable to earn a living.

Personal physician: A doctor licensed in California with an M.D. degree (medical doctor) or a D.O. degree (osteopath), who has treated you in the past and has your medical records.

Petition for reconsideration (Recon): A legal process to appeal a decision issued by a workers' compensation judge. Heard by the Workers' Compensation Appeals Board Reconsideration Unit, a seven-member, judicial body appointed by the governor and confirmed by the Senate.

Physician: A medical doctor, an osteopath, a psychologist, an acupuncturist, an optometrist, a dentist, a podiatrist or a chiropractor licensed in California. The definition of personal physician is more limited. See personal physician.

Physician's report of permanent and stationary status and work capacity (DWC form #AD 10133.36): A form to be filled out by the physician to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work or alternative work.

Pre-designated physician: A physician that can treat your work injury if you advised your employer in writing prior to your work injury or illness and certain conditions are met. See pre-designation.

Pre-designation: The process you use to tell your employer you want your personal physician to treat you for a work injury. You can pre-designate your personal doctor of medicine (M.D.) or doctor of osteopathy (D.O.) if: you have health coverage; the doctor has treated you in the past and has your medical records; prior to the injury your doctor agreed to treat you for work injuries or illnesses and; prior to the injury you provided your employer the following in writing:
(1) Notice that you want your personal doctor to treat you for a work-related injury or illness and
(2) Your personal doctor's name and business address.

Primary treating physician (PTP): The doctor having overall responsibility for treatment of your work injury or illness. This physician writes medical reports that may affect your benefits. Also called treating physician or treating doctor.

Proof of service: A form used to show that documents have been sent to specific parties.

P&S report: A medical report written by a treating physician that describes your medical condition when it has stabilized. See also permanent and stationary.

Qualified medical evaluator (QME): An independent physician certified by the DWC Medical Unit to perform medical evaluations.

Rating: See permanent disability rating.

Reconsideration: See petition for reconsideration.

Reconsideration of a summary rating: A process used when you don't have an attorney and you think mistakes were made in your permanent disability rating.

Reconsideration Unit: See appeals board.

Regular work: Your old job, paying the same wages and benefits as paid at the time of an injury and located within a reasonable commuting distance of where you lived at the time of your injury.

Request for authorization (RFA): A form that the treating doctor uses to notify the claims administrator of needed medical services.

Restrictions: See work restrictions.

Return to work program: If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the Department of Industrial Relations' special earnings loss supplement program that is also known as the Return to Work program.

Schedule for rating permanent disabilities: See permanent disability rating schedule.

Serious and willful misconduct (S&W): A petition filed if your injury is caused by the serious and willful misconduct of your employer.

Settlement: An agreement between you and the insurance company about your workers' compensation payments and future medical care. Settlements must be reviewed by a workers' compensation judge to make sure they are adequate.

Social Security disability benefits: Long-term financial assistance for totally disabled persons. These benefits come from the U.S. Social Security Administration. They are reduced by workers' compensation payments you receive.

Special earnings loss supplement program: See return to work program.

Specific injury: An injury caused by one event at work. Examples: hurting your back in a fall, getting burned by a chemical splashed on your skin, getting hurt in a car accident while making deliveries.

State average weekly wage: The average weekly wage paid in the previous year to employees in California covered by unemployment insurance, as reported by the U.S. Department of Labor. Effective 2006, temporary disability benefit increases are tied to this index.

State disability insurance (SDI): A partial wage-replacement insurance plan paid out to California workers by the state Employment Development Department (EDD). SDI provides short-term benefits to eligible workers who suffer a loss of wages when they are unable to work due to a non work-related illness or injury, or a medically disabling condition from pregnancy or childbirth. Workers with job injuries may apply for SDI when workers' compensation payments are delayed or denied. Call 1-800-480-3287 for more information on SDI.

Stipulated rating: Formal agreement on your permanent disability rating. Must be approved by a workers' compensation judge.

Stipulation with award: A settlement of a case where the parties agree on the terms of an award. This is the document the judge signs to make the award final.

Stipulations with request for award (Stips): A settlement in which the parties agree on the terms of an award. It may include future medical treatment. Payment takes place over time. This document is provided to the judge for final review.

Subjective factors: The amount of pain and other symptoms described by an injured worker that a doctor reports as contributing to a worker's permanent disability. Subjective factors are given very little weight under the 2005 rating schedule as the schedule relies mainly on objective measurements.

Subpoena: A document that requires a witness to appear at a hearing.

Subpoena Duces Tecum (SDT): A document that requires records be sent to the requester.

Summary rating: The percentage of permanent disability calculated by the DWC Disability Evaluation Unit.

Summary rating reconsideration: A procedure used if you object to the summary rating issued by the DWC Disability Evaluation Unit.

Supplemental job displacement benefit (SJDB): A workers' compensation benefit. If you were injured in 2004 or later, and have a permanent partial disability that prevents you from doing your old job, and your employer does not offer other work, you qualify for this benefit. For injuries that occurred between Jan. 1, 2004 and Dec. 31, 2012, the benefit is in the form of a voucher that promises to help pay for educational retraining or skill enhancement, or both, at state-approved or state-accredited schools. For injuries that occur on or after Jan1. 2013, the voucher can be used for training at a California public school or any other provider listed on the state's eligible training provider list. It can also be used to pay licensing or certification and testing fees, to purchase tools required by a training course, to purchase computer equipment of up to $1,000 and to reimburse up to $500 in miscellaneous expenses. Up to 10 percent, or $600 may be used to pay for the services of a licensed placement agency or vocational counselor.

Temporary disability (TD or TTD): Payments you get if you lose wages because your injury prevents you from doing your usual job while recovering.

Temporary partial disability (TPD) benefits: Payments you get if you can do some work while recovering, but you earn less than before the injury.

Temporary total disability (TTD) benefits: Payments you get if you cannot work at all while recovering.

Transportation expenses: See medical mileage.

Treating doctor: See primary treating physician.

Treating physician: See primary treating physician.

Uninsured Employers Benefit Trust Fund (UEBTF): A fund, run by the DWC, through which your benefits can be paid if your employer is illegally uninsured for workers' compensation.

Utilization review (UR): The process used by insurance companies to decide whether to authorize and pay for treatment recommended by your treating physician or another doctor.

Vocational & return to work counselor (VRTWC): If you have a permanent disability, this is the person or entity that helps you develop a return to work strategy. They evaluate you, provide counseling and help you get ready to work. A VRTWC must have at least an undergraduate degree in any field and three or more years of full time experience.

Voucher: See supplemental job displacement benefit and nontransferable voucher.

Wage loss (temporary partial disability): See temporary partial disability benefits.

Whole person impairment (WPI): For injuries on or after Jan. 1, 2013 all cases with permanent residuals will be increased by a WPI factor of 1.4.

Work restrictions: A doctor's description of the work you can and cannot do. Work restrictions help protect you from further injury.

Workers' compensation administrative law judge: A DWC employee who makes decisions about workers' compensation disputes and approves settlements. Judges hold hearings at local Workers' Compensation Appeals Board (WCAB) offices, and their decisions may be reviewed and reconsidered by the Reconsideration Unit of the WCAB. Also called workers' compensation judge.

Workers' Compensation Appeals Board (WCAB): Consists of 24 local offices throughout the state where disagreements over workers' compensation benefits are initially heard by workers' compensation judges. The WCAB Reconsideration Unit in San Francisco is a seven-member, judicial body appointed by the governor and confirmed by the Senate that hears appeals of decisions issued by local workers' compensation judges.

Workers' Compensation Insurance Rating Bureau (WCIRB): An agent of the state Department of Insurance and funded by the insurance industry, this private entity provides statistical and rating information for workers' compensation insurance and employer's liability insurance, and collects and tabulates information to develop pure premium rates.

Workers' compensation judge: See workers' compensation administrative law judge.

Important Links Labor Codes & Resources

Link to the Schedule for Rating Permanent Disabilities

Link to California Labor Code

Link to Title 8 Regulations

Labor Code § 3202
- Liberal Construction

Labor Code § 3208.3
- Requirement for Disability and/or Need for Medical Care and a Diagnosis
- Requirement for Predominant Cause (51%)
- Violent Act and Substantial Cause 35% to 40%
- Six Month Rule
- Psyche Claim Post Termination or Layoff

Labor Code § 3209.3
- Definition of Physician, Psychologist and Acupuncturist

Labor Code § 3209.5
- Medical Treatment Itemized to Include Clinical Social Workers

Labor Code § 3209.8
- Treatment Can be Supplied by Marriage and Family Therapists, Professional Clinical Counselors and Clinical Social Workers
- Care Must be Referred by a Physician Approved by the Employer
- Counselors Listed Cannot Determine Disability

Labor Code § 3600
- Conditions for Compensation
- Employee/Employer Relationship
- No Fault Basis
- Proximately Caused by the Employment
- Affirmative Defenses
    - Intoxication
    - Self-Inflicted
    - Initial Physical Aggressor
    - Commission of a Felony
    - Off-Duty Recreational Activity
    - Filed Post Termination

Important Links Labor Codes & Resources

Labor Code § 3209.10

- Treatment Can be Provided by a Physician's Assistant or Nurse Practitioner Under the Review or Supervision of a Physician or Surgeon

Labor Code § 4060

- Resolving disputed medical facts concerning AOE/COE when no part of the body is accepted as work-related

Labor Code § 4061

- Resolving disputes regarding issues regarding permanent disability

Labor Code § 4062

- Resolving disputes for all other issues not covered by Labor Code sections 4060 and 4061

Labor Code § 4062.1

- Process to request a State Panel Qualified Medical Evaluation in unrepresented cases

Labor Code § 4062.2

- Process to request a State Panel Qualified Medical Evaluation in represented cases

Labor Code § 4600

- Medical Care Defined
- Consequences for Employer's Neglect in Providing Medical Care
- Utilization Review Determines Reasonableness and Necessity of Care
- No MPN/HCO, Employer's 30 Day of Medical Control
- Requirements Regarding Predsignation of Physician
- Travel Reimbursement Regarding Employer or Administrative Director Requiring a Medical Evaluation
- Requirement to Provide a Translator for Evaluations Required by the Employer or Administrative Director
- Requirements Regarding Requesting and Providing Employee with Home Health Services

Labor Code § 4600.1

- Requirements Regarding Physician's Prescribing Generic Drug Equivalents

Important Links Labor Codes & Resources

Labor Code § 4601
- Employee Requests a Change in Treating Physician During the First 30 Days

Labor Code § 4603
- Employer's Ability to Petition for the Employee to Change Treating Physicians

Labor Code § 4603.2
- Timeframes to pay paper medical bills and penalty amounts when paid late

Labor Code § 4603
- Employer petition to the administrative director for a change of treating physician

Labor Code § 4610
- Utilization Review

Labor Code § 4616
- Medical Provider Network

Labor Code § 4650
- Timeframes to Pay Temporary Disability and Permanent Disability Benefits
- Ability to Defer Permanent Disability and Criteria to do so
- Schedule of Indemnity Payments
- Penalties for Late Payment of Indemnity Benefits
- Explanation of Salary Continuation

Labor Code § 5401
- Duty to Provide a Claim Form
- Definition of First Aid
- Contents of the Notice of Potential Eligibility Accompanying the Claim Form

Labor Code § 5401.7
- Statement Regarding Fraud Contained on the DWC-1 Claim Form

Labor Code § 5402
- Employer's Knowledge of an Injury
- Timeframe to Reject/Deny the Claim
- Authorize Medical Care within One Working Day

Labor Code § 5405
- Statute of Limitations

Important Links Labor Codes & Resources

Labor Code § 5407

- Statute of Limitations Regarding Serious & Willful Misconduct

Labor Code § 5410

- New & Further Disability

Labor Code § 5411

- Specific Injury

Labor Code § 5412

- Occupational Disease & Cumulative Trauma Injury

Labor Code 5500.5

- Rule Limiting the Timeframe to One Year to Bring in Employers on a CT Claim

California Code of Regulations (CCR) 9812

- Benefit Notice Requirements

California Code of Regulations (CCR) 9767.5

- Medical Provider Network Access Standards

California Workers' Compensation Summary Sheet

Compensation Rates

Eff Date On or After	TTD/PTD Min/Max Wkly Rate	PPD Max Wkly Rate	Mileage Reimburse Rates
1/1/24	$242.86 min $1619.15 max	$290.00	$0.67
1/1/23	$242.86 min $1619.15 max	$290.00	$0.655
1/1/22	$230.95 min $1539.71 max	$290.00	$0.625 on or after 7/1/22 $0.585 on or after 1/1/22
1/1/21	$203.44 min $1356.31 max	$290.00	$0.56
1/1/20	$194.91 min $1299.43 max	$290.00	$0.575
1/1/19	$187.71 min $1251.38 max	$290.00	$0.58

Permanent Disability Benefits

Employee Reaching MMI: The treating physician or Med-Legal evaluator will determine if the employee has reached a maximum medical improvement or MMI and at that time determine if the employee has any PD

Determination of PD: The evaluating physician must use the American Medical Association Guides to Determine Permanent Impairment, Fifth Edition. Each body part is assigned a chapter with tables assigning impairment. The physician will provide a Whole Person Impairment. This WPI will be rated by the Examiner based on the employee's age and occupation.

Payment of PD: PD is payable within 14 days of knowledge it is due from the last date of payment of TTD or determination of MMI whichever is earlier. It is paid every two weeks until paid in full unless an alternate agreement is made.

Payment of PD can be Deferred: Payment of PD can be deferred until the matter is resolved and an Award is issued, only if the employee returned to work making at least 85% of what was paid at the time of injury or 100% of wages if working elsewhere.

Determination of PD Amount to be Paid: After the WPI is rated for age and occupation, the final rating is equivalent to a number of weeks mult by the weekly PD rate

Life Pension: If the employee sustains a permanent impairment of 70% to 99%, they are entitled to benefits for life

Permanent Total Disability: If the employee is 100% disabled, they are entitled to their TTD rate for life

TTD Benefits Waiting Period: Benefits are not owed for the first three calendar days unless disability continues for a period of more than 14 days, or the employee is hospitalized as an inpatient

Cap on TTD Benefits: 104 weeks, exceptions exist

Calculating the AWW: Average of 52 wks of wages prior to date of injury

Calculating the TTD rate: AWW mult by .6667

Payment of TTD Benefits: TTD benefits are payable within 14 days of knowledge TTD benefits are owed. They are payable every 14 days thereafter.

Calculating TPD Rate: if the employee is making reduced earnings and losing wages the TPD rate is calculated by taking the average weekly wage and subtracting the reduced earnings to secure the wage loss. This figure is mult by .6667 to secure the weekly TPD rate.

Payment of TPD Benefits: Wage loss is payable within 14 days of knowledge they are due. Wage loss can be paid every 14 days or weekly depending on how the wage loss is being calculated.

Penalty for Late Payment: 10% of the amount paid late

Medical Care

Providing Medical Care: Medical care must be authorized within one day of the employee returning the DWC-1 Claim Form.

Doubting Validity of the Claim: Medical care must be provided up to $10,000.00 or until the claim is denied if the employer doubts the validity of the claim

Employer Thirty Days of Medical Control: The employer has 30 days of medical control to direct care. After this timeframe the employee can select or free choice a physician

Reasonableness & Necessity of Care: Utilization Review is the tool to determine if care requested is reasonable and necessary. Only a Licensed Physician through this process can deny, delay, or modify requested medical care.

Claim Resolution

Stipulation with Request for Award: This method of settlement memorializes the amount of PD the employee is entitled to receive and if they are also entitled to future medical care for their lifetime. PD awarded as a result of a Stipulation is paid every two weeks until paid in full.

Compromise and Release Agreement: This method settles all aspects including medical care and PD for one lump sum of money. This absolves the employer of any future liability regarding the specific claim.

Medicare Set-Aside: A MSA may be required if the employee is Medicare eligible. This is an amount of money set-aside to pay for care regarding the injury, so it is not paid by Medicare.

{DATE}

Dear {Name of Recipient}

We are aware you sustained a work-related injury resulting in time away from work per your treating physician.

This emailed notice outlines the four leave options available to CalPERS members. Each type of leave provides varying rates of pay when you are unable to work because of your work-related injury.

A three-calendar day waiting period applies to each of the four options. The waiting period is waived if:

- Time lost exceeds fourteen calendar days
- The injury is caused by a criminal act of violence against you
- You are hospitalized as an inpatient

The four leave options include:

- Industrial Disability Leave (IDL) Basic
- Industrial Disability Leave with Sick Leave Supplementation
- Temporary Disability (TD)
- Temporary Disability with Leave Supplementation

You have fifteen days from receipt of this benefits eligibility notice to notify the Campus of your selection. If you do not provide your selection timely you will be placed on Industrial Disability Leave Basic.

Below is a detailed explanation of each of the four types of leaves available.

Industrial Disability Leave | Basic

Industrial Disability Leave (IDL) Basic is a benefit that pays up to twenty-two working days at full pay. If time lost exceeds twenty-two working days, the IDL benefit drops to 2/3rds of your normal monthly gross salary.

IDL is available for a maximum of 52 weeks within a two-year period beginning with your first day of lost time from work.

When selecting to receive IDL Basic, certain deductions will continue from your pay. This includes deductions for retirement, PERS contributions, elected health benefits, parking fees as well as any other voluntary deductions or withholdings that were Ordered.

Industrial Disability Leave | After 22 Workdays Using Sick Leave to Continue Full Pay

If you are off work for more than twenty-two working days, you have a one-time opportunity to elect IDL benefits utilizing accrued sick leave to supplement 1/3rd of your salary and continue receiving your full pay.

To be eligible, you must have sick leave available at a level adequate to continue your full salary.

When selecting to receive IDL with sick leave to continue receiving your full pay certain deductions will continue from your pay. This includes, federal/state income tax, retirement, social security/Medicare, any applicable garnishments, PERS contributions, deferred compensation (457 or 401(k)), tax shelter (403(b)), elected health benefits, parking fees, pre-tax plans (HRCA, DCRA), any voluntary deductions and any withholdings that were Ordered.

Industrial Disability Leave | Eligibility Timeframes:

An eligible employee may receive IDL payments for a period not to exceed 52 weeks within two (2) years from the first day of disability.

Temporary Disability

When IDL eligibility is terminated or you elect to receive temporary disability instead of IDL, the below is explanation of how these benefits are paid.

Temporary Disability payments are issued by the Third-Party Administrator (TPA) directly to the injured employee every two weeks.

TD payments are non-taxable. The weekly TD rate is based on two-thirds of the employee's average weekly wage determined by the date of injury and is subject to the minimum and maximum amounts set by California Statute. These rates are established by our Third-Party Claim Administrator.

TD payments have no mandatory or voluntary deductions withheld after Family Medical Leave has been exhausted.

When receiving TD payments either by election or expiration of IDL, you are responsible to pay the full health coverage premium, which includes both your share and that of the campus. Under this circumstance, you will need to coordinate with the campus regarding your responsibility to pay the full premium.

Temporary Disability | Using Available Accrued Leave to Continue Full Pay

When IDL eligibility is terminated or you elect to receive temporary disability instead of IDL, other accrued leave credits can be used to bring you up to full pay.

In this option, accrued leave credits will be utilized to make up the difference between the full month gross pay and the temporary disability rate. Temporary disability is subject to California State Statutory minimum and maximum rates.

When selecting to receive temporary disability utilizing leave credits to receive full pay certain deductions will apply. This includes applicable federal/state income taxes, retirement, social security/Medicare, garnishments, PER contributions, deferred compensation (457 or 401(k)), tax shelter (403(b)), elected health benefits, parking fees, pre-tax plans (HRCA, DCRA), any voluntary deductions and any withholdings that were Ordered.

Employee Optional Election | One Time Opportunity to Change Benefits Election

Employees will be given a one-time opportunity to change their leave election.

At any time during the first ninety calendar days of absence, the disabled employee may notify his/her campus to change benefits from IDL to TD benefits or vice versa.

Such a change shall be a one-time opportunity and shall be effective on the 90th calendar day of absence.

Please contact me so we can determine your elections and answer any questions or concerns you may have.

Best regards,

Enclosures: Comparison of Workers' Compensation Temporary Disability and Industrial Leave Benefits
Disability and Payment Deductions Regarding Leave Election

Disability Payment/Deductions					
IDL = Industrial Disability Leave					
TD = Temporary Disability Leave					
Type of Deduction	**IDL @ Full Salary First 22 Working Days***	**IDL @ 2/3rd Salary on the 23rd Day**	**IDL @ 2/3rds Supplementing Remainder with 1/3rd Sick Leave****	**TD 2/3rds of Wages Subject to Maximum State Rates**	**TD Supp Shortfall in Wages with Leave Credits*****
Federal/State Income Taxes	No	No	Yes[1]	No	Yes[1]
Retirement	Yes	Yes	Yes	No	Yes[1]
Social Security/Medicare	No	No	Yes[1]	No	Yes[1]
Medicare	No	No	Yes[1]	No	Yes[1]
Garnishments	No	No	Yes[1]	No	Yes[1]
Order Assigning Salary or Wages for Support	Yes	Yes	Yes	No	Yes[1]
Voluntary Child Support	No	No	Yes[1]	No	Yes[1]
Earning Withholding Order for Support	Yes	Yes	Yes	No	Yes[1]
Dues/FairShare	Yes[2]	Yes[2]	Yes[2]	No	Yes[1,2]
Deferred Compensation (457 or 401(k))	No	No	Yes[1]	No	Yes[1]
Tax Shelter (403(b))	No	No	Yes[1]	No	Yes[1]
Health Benefits (Medical, Dental, Vision, Employer Paid Life, Employer Paid LTD)	Yes[3]	Yes[3]	Yes	No	Yes[1]

Parking	Yes[3]	Yes[3]	Yes[1]	No	Yes[1]
Pre-Tax Plans (HRCA, DCRA)	No	No	Yes[1]	No	Yes[1]
Voluntary Deductions (Credit Union, Scholar Share, Auto Insurance, Life Insurance)	Yes	Yes	Yes	No	Yes[1]
Yes[1] If the gross amount from the supplementation is sufficient, these deductions will automatically continue					
Yes[2] Deducted automatically unless the employee is not covered by a Collective Bargaining Agreement.					
Yes[3] Deducted on an AFTER-TAX basis.					
***First 22 Days IDL Paid at Full Salary**					
****With Utilization of Sick Leave to Continue Full Salary. Sufficient Bank of Sick Leave is Required.**					
*****Payments are Mailed Directly to the Injured Employee from the Workers' Compensation Administrator**					