

**State of California
Department of Industrial Relations
Division of Workers' Compensation**

***Physician's Guide to
Medical Practice in the
California Workers' Compensation System***

Fourth Edition, 2016

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Commonly Used Acronyms

8 CCR	California Code of Regulations, Title 8
ACOEM	American College of Occupational and Environmental Medicine
AD	administrative director
AMA	American Medical Association
AME	Agreed Medical Evaluator
AOE	arising out of employment
CF	conversion factor
CMS	Centers for Medicare and Medicaid Services
COE	course of employment
DEU	Disability Evaluation Unit
DIR	Division of Industrial Relations
DOI	date of injury
DOSH	Division of Occupational Safety and Health
DWC	Department of Workers' Compensation
EBM	evidence-based medicine
EOR	Explanation of Review
GAF	Global Assessment of Function
HCO	health care organization
IBR	independent bill review
IBRO	independent bill review organization
IMR	independent medical review
MEEAC	Medical Evidence Evaluation Advisory Committee
MPN	medical provider network
MPPR	Multiple Procedure Payment Reduction
MTUS	medical treatment utilization schedule
OMFS	Official Medical Fee Schedule
OSHA	Occupational Safety and Health Administration
PA	physician's assistant
P&S	Permanent and Stationary
PTP	primary treating physician
QME	Qualified Medical Examiner
RBRVS	Resource-Based Relative Value Scale
RVUs	Relative Value Units
SIBTF	Subsequent Injuries Benefits Trust Fund
SJDB	Supplemental Job Displacement Benefits
TD	Temporary Disability
TPD	Temporary Partial Disability
TTD	Temporary Total Disability
TPA	third-party administrator
UEBTF	Uninsured Employers Benefits Trust Fund
UR	utilization review
URO	utilization review organizations
WCAB	Workers' Compensation Appeals Board
WPI	Whole Person Impairment

Introduction to the Fourth Edition

This edition of the *Physician's Guide to Medical Practice in the California Workers' Compensation System (Physician's Guide)* has been developed by the Division of Workers' Compensation (DWC) to continue the mission set forth in the first three editions of the *Physician's Guide*, namely, to assist physicians in understanding the many complexities in the California workers' compensation system in order to provide optimal care to ill and injured workers.

Vast changes to the workers' compensation system have occurred since the *Physician's Guide* was last revised in 2001. This manual is intended to provide a current overview of the workers' compensation system, benefits generally provided in California, state government agencies involved in administering the system, and the role of physicians, employers, workers, and others involved in the system.

The purpose of the *Physician's Guide* is to put practical and usable information in the hands of physicians who are caring for injured workers in California, but it is not intended to replace clinical judgment. It is meant to be consistent with current laws and regulations but is *not* meant to be a legal treatise or include legal citations in support of each of the statements presented. The regulations are found in the California Code of Regulation, Title 8, and are cited throughout this guide as "8 CCR ____." Many of the issues covered in this edition are being litigated almost daily, and, in some cases, reasonable minds differ as to their meaning. The *Guide* is intended as an educational tool to supplement the reader's professional experience and provide a convenient reference for information about the operation of the system. The DWC web page is regularly updated. Readers are advised to refer to the [DWC website](#) for the most recent information.

Chapter 1

The California Workers' Compensation System

Key concepts:

- The Historic Compromise and "No Fault" Rule
- The Evolution of Workers' Compensation in California

History of Workers' Compensation

Workers' compensation systems in the United States were established in the early twentieth century. Prior to that, employees injured on the job might pursue a civil tort action against their employer to recover losses due to their injury. But because few injured workers could afford to hire a lawyer and many were deterred by the fear of losing their job, this was not an option for most. Employees who went to court had the difficult task of proving that their injury was caused by the employer's negligence. Even if the employees could prove negligence, employers commonly avoided liability by claiming that the workers' own negligence had contributed to their injury, that another employee's action had caused the injury, or that the employees were aware of the danger but had chosen to continue to work and had therefore assumed the risk.

Seventeen days after a devastating fire at the Triangle Shirtwaist Company factory in New York City claimed the lives of 146 young workers in 1911, California passed its first workers' compensation act. However, the provision of workers' compensation coverage remained voluntary for employers. The passage of the Boynton Act in 1913 finally required most employers to have workers' compensation coverage and established the State Compensation Insurance Fund, which opened its doors the following year. In 1917, the Workers' Compensation Insurance and Safety Act replaced the Boynton Act. The new act substantially copied the provisions of the Boynton Act, but added the provision that, when rating permanent disability, "consideration be given to the diminished ability of such an injured employee to compete in the open labor market." In 1951, the California State Senate decided that the new language "imposed the obligation to make due allowance for obvious physical impairments and due allowance for such disabling subjective factors as, for example, pain, discomfort, and psychiatric or mental disturbances, provided, of course, the subjective factor or factors be considered to be of a permanent nature." Over the years, required coverage has been expanded to include all employees, including farm workers, most domestic and household employees, and state prison inmates in some instances. Federal, maritime, and railroad employees are covered under separate workers' compensation systems that are not part of California's system.

In short, the workers' compensation system was created to pay for the medical treatment of work-related injuries or illnesses and provide temporary payment for lost wages and permanent disability payments that compensate for an injured employee decreased ability to compete in the open labor market.

The Historic Compromise: A Trade-Off between Employers and Employees

A workers' compensation system makes compromises by trading rights and benefits between employers and employees: the employee gives up the right to pursue what might otherwise have been a very large monetary award in exchange for a system that guarantees prompt delivery of

benefits and provides legal protection against discrimination. The employer provides workers' compensation benefits regardless of fault, in exchange for protection against civil action by the employee. This exchange, often called the "historic compromise," has three components:

- *No Fault*: The employer is required to pay benefits no matter who caused the injury, as long as the injury arose out of or occurred in the course of employment.
- *Exclusive Remedy*: Unless the employer is uninsured, the worker cannot pursue other forms of recovery from the employer, even if the employer was grossly negligent. (If a third party contributed to an injury or death, as might occur with a work-related car accident, the third party may be sued.)
- *Assured and Fixed Benefit*: The workers' compensation system establishes defined benefits, which must be paid for by the employer. Workers' compensation awards are typically far less than comparable negligence awards in a civil suit. For example, although the maximum workers' compensation death benefit may be far less than the possible award in a civil wrongful death suit, a civil action may take years to resolve while a death claim can be resolved in as little as a few months. Additional recoveries are available to employees for an employer's serious and willful misconduct and unlawful discrimination (Labor Code § 132a and § 4553). Although group health coverage may include arbitrary limits on the extent of treatment covered, workers' compensation is a statutory benefit with no arbitrary limits on the frequency, duration, or extent of services.

Exceptions to the "No Fault" Rule

The "no fault" rule has exceptions. For example, deliberately self-inflicted injuries are excluded from coverage (Labor Code § 3600). For injuries that result from the serious and willful misconduct of the injured employee, benefits are reduced by half, unless the injury resulted in death or a permanent disability of 70% or more; the injury resulted from failure of the employer to comply with the law or safety and health regulations; or the employee was under 16 years old at the time of injury (Labor Code § 4551). For injuries that result from the serious and willful misconduct of the employer, the employee's compensation is increased by half (Labor Code § 4553). Serious and willful misconduct is generally difficult to prove, so these penalties are rarely imposed. The Workers' Compensation Appeals Board must make the finding of serious and willful misconduct before any awards can be reduced or increased.

Evolution of Workers' Compensation in California¹

Over the past 20 years, rising prices have led to frequent attempts to control costs, primarily to employers, who expend significant amounts on insurance, claims payments, legal and medical costs, and other aspects of workers' compensation. Thus the workers' compensation system continues to evolve in ways that affect physicians and other participants.

In 1989 and 1993, measures were enacted to address the Qualified Medical Evaluator (QME) process, a fee schedule for medical legal examinations, physician referral, advertising, the compensability of psychiatric and post-termination claims, fraud deterrence, and benefit payments for injured workers.

¹ The evolution of legislation and the resulting financial impact can be traced in more detail in the [annual reports of the Commission on Health and Safety and Workers' Compensation](#).

Chapter 1

In 2003 and 2004, measures were enacted that allowed employers (1) to establish medical provider networks—from which injured workers are required to select treating doctors, (2) to conduct utilization review to ensure that medical care was consistent with evidence-based guidelines, and (3) to limit the amount of physical therapy and chiropractic treatment. These measures also affected permanent disability ratings and benefit payments to injured workers. An evidence-based medical treatment utilization schedule (MTUS), or set of guidelines, was also adopted.

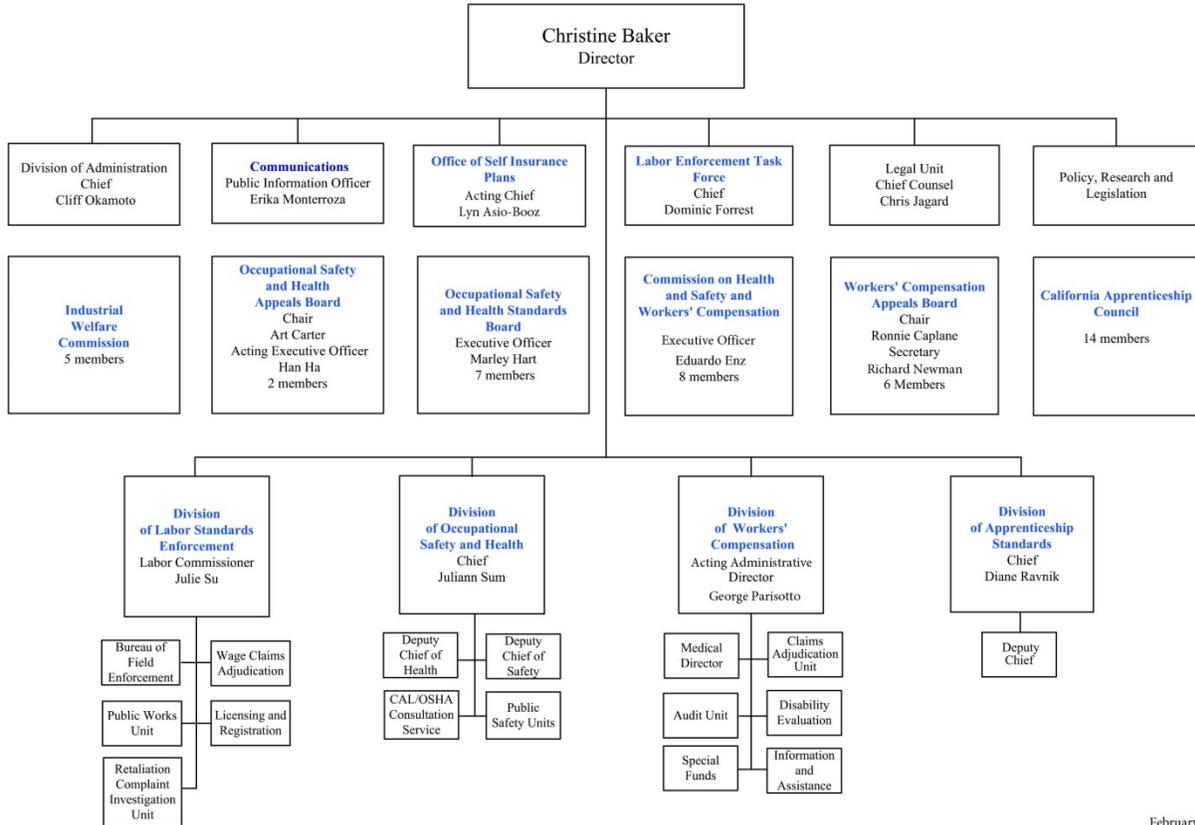
In 2013, measures were enacted that made wide-ranging changes, which included (1) increasing permanent disability paid to injured workers and simplifying the permanent disability rating method, (2) resolving medical treatment disagreements through independent medical review and bill payment disputes through independent bill review, (3) improving medical provider networks, and (4) updating the Official Medical Fee Schedule and establishing fee schedules for copy services, interpreters, vocational experts, and in-home health care.

Chapter 2

Organization of the Workers' Compensation System within State Government

Department of Industrial Relations

Director Christine Baker reports to the Secretary of the California Labor & Workforce Development Agency, David M. Lanier, who in turn reports to Governor Edmund G. Brown Jr. as a member of his Cabinet.



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Key concepts:

- Division of Workers' Compensation (DWC)
- Workers' Compensation Appeals Board (WCAB)
- Audit Unit
- Disability Evaluation Unit (DEU)
- Information and Assistance (I&A) Unit
- Legal Unit
- Medical Unit
- Research Unit
- Workers' Compensation Information System
- Uninsured Employers Benefits Trust Fund (UEBTF)
- Subsequent Injuries Benefits Trust Fund (SIBTF)

California's Division of Workers' Compensation (DWC)

The Division of Workers' Compensation (DWC) monitors the administration of workers' compensation claims and provides administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers' compensation benefits. DWC's mission is to minimize the adverse impact of work-related injuries on California employees and employers. At the DWC's [24 district offices](#) and satellites located around the state, also called Workers' Compensation Appeals Boards (WCABs) or "boards," employers, injured workers, and others receive judicial services to assist in the prompt and fair resolution of disputes that sometimes arise from workers' compensation claims. Local district offices are a major part of the workers' compensation court system, where administrative law judges make decisions about cases. Appeal from this level is available by Petition for Reconsideration to a statewide panel of commissioners. Decisions issued by the WCAB are appealable to the state trial courts, and then to the California Courts of Appeal and the California Supreme Court. The administrative director (AD) is vested with authority to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon the AD under the Labor Code. The AD oversees the diverse programs of the DWC and oversees the implementation of workers' compensation reforms.

The Workers' Compensation Appeals Board (WCAB)

Distinct from the "boards" mentioned above, the WCAB is a judicial body consisting of seven commissioners, appointed by the governor, and confirmed by the Senate. Major functions of the WCAB include review of Petitions for Reconsideration of decisions by Workers' Compensation Administrative Law Judges and regulation of the adjudication process by adopting rules of practice and procedure.

The Audit and Enforcement Unit

The Audit and Enforcement Unit conducts audits of insurance companies, self-insured employers, and third-party administrators to ensure that they have met their obligations under the Labor Code

and DWC's regulations. By assessing penalties and ordering that carriers to pay compensation that is owed to injured workers, this unit ensures that proper benefits are delivered accurately and in a timely manner.

Disability Evaluation Unit (DEU)

The DEU determines permanent disability ratings by evaluating medical descriptions of physical and mental impairment. The determinations are used by Workers' Compensation Administrative Law Judges, injured workers, and insurance claims administrators to determine permanent disability benefits. The DEU prepares three types of ratings:

- Formal, done at the request of a workers' compensation judge
- Consultative, done on litigated cases at the request of an attorney or DWC information and assistance officer
- Summary, done on non-litigated cases at the request of a claims administrator or injured worker.

Information & Assistance (I&A) Unit

The DWC I&A Unit provides information and assistance to employees, employers, labor unions, insurance carriers, physicians, attorneys, and other interested parties concerning rights, benefits, and obligations under California's workers' compensation laws. The unit plays a major role in reducing litigation before the WCAB and is often the first DWC contact for injured workers.

The unit's I&A officers assist in the resolution of misunderstandings, disputes, and complaints arising out of claims for compensation. The I&A officers also conduct seminars for injured workers on a monthly basis at each of DWC's 24 local district offices. At the seminars, employees get information on their right to medical treatment, disability payments, returning to work after an injury, and resolving a disagreement over a claim.

Additional information is available that may be helpful:

- *Workers' compensation benefits*: Overview of benefits, including current rates, available for injured workers
- *Fact sheets and guides for injured workers*: Answers to frequently asked questions and "how to" guides for forms
- Glossary of workers' compensation terms for injured workers
- *Workers' compensation reference materials*: Other sources of information on the workers' comp system
- Medical mileage expense form in both English and Spanish
- Simplified flowchart for the claims process

Medical Unit

Under the direction of the executive medical director, the Medical Unit performs a variety of services related to the delivery of medical benefits in the workers' compensation system. It establishes policy and guidelines for the treatment and evaluation of injured workers. The unit examines and appoints physicians to be Qualified Medical Evaluators (QMEs), who in turn examine injured work-

ers to help resolve medical disputes. The unit also investigates complaints filed against QMEs concerning violations of the Labor Code and regulations as well as other statutes for misconduct committed in the QME process (Chapter 13). The Medical Unit also approves or certifies and oversees medical provider networks (MPNs) and health care organizations (HCOs) that provide care to injured workers (Chapter 6). The unit reviews utilization review (UR) plans and handles UR complaints and investigations jointly with the Audit Unit (Chapter 13) and reviews independent medical review (IMR) and independent bill review (IBR) requests to determine eligibility (Chapters 9 & 12). The Medical Unit also assists the AD with other issues affecting providers in the workers' compensation system, such as setting medical fee schedules (Chapter 12).

Additional details are available on the following Medical Unit Programs:

- Discipline Unit
- e-billing
- Health care organizations (HCO)
- Independent bill review (IBR)
- Independent medical review (IMR)
- Medical provider network (MPN)
- Medical treatment utilization schedule (MTUS)
- Official medical fee schedule (OMFS)
- Qualified Medical Evaluator (QME) process
- Standardized paper billing
- Utilization review (UR)

Workers' Compensation Information System (WCIS)

WCIS uses electronic recordkeeping data interchange to collect comprehensive information from claims administrators to help DIR oversee the state's workers' compensation system. This information helps facilitate evaluation of the system and measure adequacy of benefits for injured workers and their dependents, and provides statistical data for research. As of September 22, 2006, all elements of a workers' compensation claim including employers' first reports of injury, benefit notices, and reporting of medical billing are required to be electronic.

Uninsured Employers Benefits Trust Fund (UEBTF) and Subsequent Injuries Benefits Trust Fund (SIBTF)

Claims are paid from the UEBTF when illegally uninsured employers fail to pay workers' compensation benefits awarded to their injured employees by the WCAB. Certain steps must be taken before and after the issuance of an award in order to receive benefits from the UEBTF. *How to File a Claim with the Uninsured Employers Benefits Trust Fund* is a guide offering detailed steps to pursue a claim for benefits from the UEBTF.

The SIBTF is a source of additional compensation to injured workers who already had a disability or impairment at the time of injury. For benefits to be paid from the SIBTF, the combined effect of the injury and the previous disability or impairment must result in a permanent disability of at least 70%. The fund enables employers to hire disabled workers without fear of being held liable for the effects of previous disabilities or impairments. SIBTF benefit checks are issued to injured workers by the SIBTF Claims Unit after benefits are awarded by the WCAB. The Application for Subsequent Injuries and Benefits must be completed to obtain SIBTF benefits.

Chapter 3

Compensability

Key concepts:

- How to Take a Complete Occupational History
- How to Define:
 - An Injury
 - First Aid
- Aggravation
- Recurrence
- Arising Out of Employment (AOE)
- Occurring in the Course of Employment (COE)
- Causation
- Presumptions
- Psychiatric Injuries

Workers' compensation is a medically driven system designed to provide injured workers with medical treatment, an income maintenance allowance, and other indemnity benefits (benefits that compensate, in part, for injury, loss, or damage). The term "medically driven" means that medical information is used to guide key decision points in the system, including entry into the system.

Physicians may be asked to evaluate an injured worker's condition. Labor Code §3209.3 defines physicians as including physicians and surgeons holding an MD or DO degree, psychologists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California law. The **physician's opinion provides much of the basis for a claims administrator to start or deny benefits**. Many claims can proceed to a rapid and fair resolution, with no dispute, if the physician prepares detailed, accurate, and unbiased reports. In contested cases, physicians are asked to provide expert opinion on particular medical issues for a party to the case. Physicians provide evidence that the workers' compensation judge may use to make a decision. The physician's opinion is almost always in the form of a written report. It is critical for physician reports to be complete, accurate, and carefully written, with conclusions that are consistent with the rest of the report. An especially important part of the report is the occupational history (see below).

How to Take a Complete Occupational History

In the workers' compensation system, words have very specific meanings. The way in which a physician uses certain words or concepts can open or close doors to the various benefits an injured worker may need. Because of this, it is very important for physicians to use workers' compensation "language" to convey the intended meaning. This section explains basic concepts that physicians need to know in order to function effectively and responsibly in this system.

The importance of taking a complete occupational history, especially in the case of cumulative injuries and occupational illness, cannot be overstated. A complete occupational health history should contain information on all the jobs the worker has held, including the length of the worker's employment, the specific job duties, how much time was spent on different tasks, any hazards (e.g., dusts or solvents) to which the worker was exposed, and what kind of protective

equipment was used. An example of an occupational history is available at www.epa.gov/pesticide-worker-safety/pesticide-poisoning-handbook-section-vi-appendices/.

What Is an “Injury”?

For the purposes of the workers’ compensation system, the Labor Code defines an **injury** as:

- Any injury or disease arising out of employment (Labor Code § 3208)
- Any “derivative” injury caused by the treatment of an injury arising out of employment
- Any reaction to or side effect from preventive health care the employer provides to health-care workers (Labor Code § 3208.05).

Injuries may be **specific** or **cumulative**. A specific injury occurs as the result of a single incident or exposure. A cumulative injury results from repetitive trauma (mental or physical) over a period of time (Labor Code § 3208.1). For example, a worker who falls and injures his/her back has suffered a specific injury. A worker has a cumulative injury if, for example, he/she lifts objects regularly and, as a result, has developed lower back pain that gets progressively worse, whether the person continues to work for that employer or moves on to another job.

In order for a condition to be considered an injury, it must either cause disability (described below) or result in a need for medical treatment. A condition that causes no lost work time or does not interfere with an employee’s ability to work is not considered an injury by the workers’ compensation system.

First aid is defined as any one-time treatment and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care (Labor Code § 5401(a)). First-aid treatment may be provided by a physician or registered professional. For example, a worker drops a heavy box on his toe. The company’s occupational nurse puts ice on the toe and sends the worker home an hour early. The worker returns to work the next morning, with no further problems. **An employer is not required to provide a worker with a claim form or submit an Employer’s First Report (Chapter 4) when first-aid treatment is provided. However, a physician rendering first-aid treatment must submit a Doctor’s First Report (Chapter 7) to the employer’s claims administrator.**

An **occupational disease**, as the term is used in California, is a disease that in whole or in part was caused by work. Occupational diseases can include diseases that, under other circumstances, may have occurred without a relationship to work. For example, a health-care worker who contracts tuberculosis from a patient has sustained an occupational disease injury, even though the disease would not have been occupational if he had contracted the disease in a non-occupational setting.

Occupational diseases can arise from exposure to chemical agents, such as mercury or organic solvents; physical agents, such as noise, cold, radiation, or vibration; biological agents; or repetitive motions, such as kneeling, lifting, or typing. Treatment rendered for pesticide poisoning or a condition suspected as pesticide poisoning can never be considered first aid (Labor Code § 6409.3).

Excluded Injuries

The Labor Code (LC § 3600) specifically excludes from compensation seven types of injuries:

- Injuries caused by the employee's use of alcohol or illegal controlled substances (if it can be shown that the injury would not have occurred otherwise, which is often difficult to substantiate)
- Intentionally self-inflicted injuries
- Suicide
- Injuries resulting from altercations, in which the injured employee is the "initial physical aggressor"
- Injuries resulting from the employee's commission of a felony, for which the employee has been convicted (this includes "wobbly felonies," which are crimes that may be prosecuted as misdemeanors or felonies)
- Injuries resulting from off-duty recreational activities, in which participation in the activities does not constitute part of the employee's work-related duties and the activity is not an expressed or implicit condition of employment
- Psychiatric injuries claimed after notice of termination/layoff unless certain conditions exist.

What Is a Compensable Injury?

An employer must provide compensation, without regard to negligence, for "any injury sustained by his or her employees **arising out of and in the course of the employment.**" Four basic conditions must be met for a workers' compensation claim to be established:

- There must be an "injury" (physiological or psychological harm).
- There must be an employment relationship.
- The injury must have been caused by the employment. (This is also referred to as arising out of employment [AOE]. See below for an expanded definition of this concept.)
- The injury must occur in the course of the employment (COE), that is, at the time of the injury, the employee must have been performing a service that grew out of and was incidental to the employment. (See below for an expanded definition of this concept.)

Physicians enter crucial details into the system by defining the injury and then establishing whether and how the injury is related to the employment. Physicians do not usually provide information regarding the employment relationship or whether the injury occurred COE.

What Is Considered an Aggravation of a Pre-Existing Non-Industrial Condition?

Under California law, a worker who suffers an on-the-job **aggravation** of a **non-industrial** pre-existing disease or underlying condition has sustained a new injury. For example, if a worker has arthritic deterioration in her knee and then falls on her knee and is unable to continue to work, the fall constitutes an injury. An aggravation causes a temporary or permanent increase in disability, creates a new need for medical treatment, or requires a change in the existing course of treatment.

Symptoms that are from a "**flare-up**" or "**recurrence**" of a previous **industrial** injury or illness, but have not been caused by the current employment, do not constitute a new injury. In other words, responsibility for compensation would lie with the employer where the worker was employed when the original injury was sustained.

What Is the “Date of Injury” and Why Is It Important?

In every workers’ compensation claim, it is necessary to establish the **date of injury (DOI)**. In a specific injury, the DOI is simply the date on which the incident or exposure occurred (Labor Code § 5411). In a **cumulative injury** or **occupational illness**, the DOI (for statute of limitation purposes) is the date when the employee first suffered disability from the exposure, and either knew, or should have known, that the disability was caused by present or previous employment (Labor Code § 5412). An employee may have had symptoms resulting from the cumulative injury or the disease for a period of time, even years, before the DOI.

The DOI is important because it determines:

- The statute of limitations for particular procedures within the workers’ compensation system
- The regulations that will apply to the worker’s injury
- The compensation rate for the worker’s injury
- The employers who are liable for the claim.

Important time limits controlled by the DOI include how long a worker has:

- To file a workers’ compensation claim
- To file a claim with the appeals board.

The DOI is used to identify the claim; employers must record the DOI on the log of injuries and illnesses.

Is the Injury Work-Related (AOE/COE)?

An injured worker has the burden of proof to show by a preponderance of the evidence that an injury is work related. Work activities need not be the sole cause of the injury or even the primary cause. Except in psychiatric cases, it is sufficient that the employment contributed to the injury to a significant degree. (Psychiatric injuries are covered further later in this chapter.)

The question of whether an injury is work related is divided into two parts (Labor Code § 3600):

- Did the injury “arise out of employment” (AOE)?
- Did the injury “occur in the course of employment” (COE)?

Arising Out of Employment (AOE)

Because the physician provides direct evidence on whether and how the activities of work led to the current injury, the physician answers the question of whether the injury arose out of employment (AOE). In a specific injury, establishing AOE may involve giving a description of an incident and the resulting harm to the patient. It is very important to obtain and document detailed information about how the injury occurred. These details can help clarify whether the injury is work related.

In cumulative injuries and occupational illnesses, the physician’s medical opinion regarding the relationship between workplace risk factors and activities and the resulting disease or disability is critical. There are some well-documented relationships between specific cumulative exposures and diseases, such as asbestos and asbestosis or mesothelioma, coal dust and coal worker’s pneumoconiosis (black

Box 3-1. Case Example: Possibility or Probability?

In *Rosas v. WCAB* (1990) 16 Cal App 4th 1692; 58 CCC 313, a wastewater treatment worker was exposed to raw sewage for many years in the course of his employment maintaining sewage system flow regulators. He later contracted hepatitis, which was held to be non-industrial in nature by the WCAB. The medical evidence conflicted, in that some evidence indicated that it was likely that such occupational exposure was the cause while other evidence indicated that the cause and method of transmission were uncertain. The court reversed the WCAB decision and held that proof of absolute certainty or absolute scientific verification was not required to prove the worker's claim. All that is required is proof of a reasonable medical probability.

This case illustrates the critical nature of taking a complete history and understanding all relevant factors involved in the work environment. A physician's failure to take an adequate occupational history can lead to disputes like this one.

lung disease), vinyl chloride and angiosarcoma of the liver, and organophosphate pesticides and certain neurological impairments. Similarly, the medical literature documents links between repetitive motions, such as those performed on assembly lines or at video display terminals and certain musculoskeletal conditions. There are also a few well-documented biological markers of disease or exposure, such as x-ray evidence of pleural plaques and interstitial fibrosis in asbestos exposure, measurements of lead in the blood or bones following exposure to lead, or plasma and red cell cholinesterase from organophosphate pesticide exposure.

However, there are many exposures, pathologies, and diseases that have not been as fully investigated or for which the causal mechanism is not known. The lack of conclusive epidemiological or toxicological studies should not, in itself, invalidate a worker's claim. In giving evidence on these claims, you are being asked whether the combination of existing medical and scientific knowledge and the occupational and medical history of the individual worker leads you to conclude with "**reasonable medical probability**" (i.e., that it is more likely than not) that the work exposure contributed to the injury.

Analyzing Causation

The determination of medical causation is essential in workers' compensation evaluations for the continuation of benefits and for the prevention of occupational disease and injury. The treating or evaluating physician is often asked to express an opinion about medical causation, that is, whether the occupational illness or injury arose out of employment (AOE). In other words, the physician is asked to indicate whether it is "more likely than not" (in other words, there is at least a 51% likelihood) that the work exposure or incident played a significant role in producing the pathological condition or disability that the physician described.

Three factors need to be established in order to make a causation determination:

1. What pathological condition(s) (and disability) are present?
2. What relevant work exposures were present?
3. What other causes might produce the disease (i.e., non-industrial exposures)?

Only after all three have been considered can causation be adequately addressed. Therefore, a report should include documentation of the specific nature of the workplace hazard (e.g., whether the individual was exposed to chemicals, ergonomic hazards, or mental stress and the duration and in-

Box 3-2. Types of Causation

There are five major types of causation:

Direct Causation: The work exposures are directly responsible for the health outcomes.

Contributing Cause: Several factors led to the disease; work exposure is one of these factors.

Acceleration: The disease process is accelerated by virtue of work exposure. The date of the onset of the disease is much sooner than it would have been in the absence of the exposure.

Precipitation: The work exposure “precipitates” the manifestation of the illness. For example, an underlying tendency or asymptomatic problem was present, but the work exposure causes it to clinically manifest.

Aggravation: A medical condition may be present already, but work exposure makes it worse.

tensity of exposure to the hazard. In addition, if the disease was caused by work, the physician should explain whether the disease produced sufficient impairment (loss of function) to lead to disability.

Causation is a simple question in specific injuries. A woman with no previous medical history falls from a ladder, breaks her shoulder, and, after completing the course of medical treatment, still has moderate pain and a reduced range of motion in her shoulder. The cause of the disability is the injury to her bone and soft tissues as a result of the fall. However, if a woman with a prior history of shoulder pain has the same accident and undergoes the same treatment with the same results, there also may be a dispute as to whether her previous shoulder pain constituted a significant or ratable disability or degree of any permanent disability. A case like this would require the physician to inquire further into the patient’s history to determine the factors of disability that existed prior to the recent industrial incident. Prior pathology alone is not sufficient; the physician must document both prior impairment and the resulting pre-existing factors of disability. If prior pathology did not cause actual prior disability, the physician should so state.

Causation: Cumulative Injuries and Illnesses

In determining the causation in occupational illnesses or cumulative injuries, the same reasoning applies. The physician must first determine the cause of the injury. For example, a worker with a history of asbestos exposure develops restrictive lung disease, including reduced vital capacity and shortness of breath. X-rays reveal pleural plaques and fibrosis, particularly in the lower region of the lung. The impairment is reduced lung function, which was caused by asbestos exposure.

Similar reasoning applies in the case of an asbestos-exposed worker who was evaluated for lung cancer. Asbestos exposure is a known risk factor for lung cancer, and the X-ray examination provided evidence of significant asbestos exposure. Even though the worker had other risk factors for lung cancer, such as smoking, the physician concluded that the asbestos exposure significantly increased the worker’s chance of developing cancer. In this case, the lung cancer resulted in the removal of part of a lung and a work restriction to semi-sedentary work; the asbestos exposure was again considered to have caused the injury (cancer), and the injury was considered to have caused the disability.

Box 3-3. Case Example: Taking Employees as You Find Them

During her normal workday, a school crossing guard suffers a heart attack and dies a week later. Medical records indicate that she had undiagnosed, non-industrial coronary artery disease at the time of her death. Her duties involved walking to the center of the street and holding a “stop” sign as children crossed. She did this 10-15 times in 25- minute shifts. The reporting physicians concluded that, given her condition, even minimal activity could have caused the heart attack. The judge found industrial causation, which was upheld by the WCAB. *City of Arroyo Grande v. WCAB* (64 CCC 1147).

What Is the Effect of Other Risk Factors on the Cause of the Injury?

Most employees are not perfectly healthy before incurring an occupational injury and do not lead perfectly healthy lifestyles. A basic principle of workers’ compensation law is that the employer “takes employees as they find them.” The employer cannot avoid liability for an occupational injury by claiming that the injury would not have happened if the worker had been in a different physical or emotional condition before the accident. Workers who smoke, drink, or do not get physical exercise are still entitled to workers’ compensation benefits for their occupational injuries.

For example, consider a worker with diabetes who cuts his foot at work and develops a severe infection. The evaluating physician might determine that the diabetes increased the worker’s chance of infection and may even believe that a worker without diabetes would not have developed an infection. However, the infection would not have developed at this time without the cut. Therefore, the infection and any complications of the infection are compensable under workers’ compensation.

Establishing the Cause of Cumulative Injuries and Illnesses

When considering cumulative injuries and occupational illnesses, the relationship of the work activity to the disability may not be as obvious as in specific injuries. There is simple cause and effect between a cement block falling on a worker’s foot, the crushing injury, and a resulting permanent work restriction to semi-sedentary work. But the relationship between work and illness is not as clear-cut in a painter who, after working in the trade for 25 years, complains of memory loss, lack of concentration, and mood swings. All these symptoms *might* result from long-term exposure to solvents in paints, but they may also be due to other non-work-related factors.

There are evaluation guidelines for some occupational diseases, such as asbestos-related lung disease, or coal worker’s pneumoconiosis. But, for other occupational diseases, the physician needs to assess causation by weighing various factors, such as the following:

- The kind of exposure involved (names or types of chemicals, activities involving repetitive motion, etc.)
- The level, frequency, and duration of exposure

Box 3-4. Case Example: The Physician Does Not Decide COE

A patient requests an evaluation of flexor tenosynovitis of the hands and wrist with associated carpal tunnel syndrome. The patient states that she uses her hands “furiously” at work doing manual tasks. The employer states that the patient hardly uses her hands at all on the job, but that the patient is an avid knitter at home. A job description provided by the employer describes almost no use of the hands in the workplace. The patient rebuts, stating that the job description is inaccurate. The doctor then takes the history and tries to determine how much hand overuse (if any) occurred on the job and how much occurred off the job. Ultimately, however, the judge decides whether the injury occurred in the course of employment (COE). The doctor states that using one’s hands doing electronics components assembly for five hours a day at work (as the patient asserts) can cause flexor tenosynovitis and carpal tunnel syndrome and that knitting every evening for three hours (as the employer asserts) can also cause flexor tenosynovitis and carpal tunnel syndrome. The doctor should also describe how a combination of the two activities could contribute to the illness. The judge will decide which of the two histories is correct. If the judge determines that both activities occurred and that, based on the doctor’s report, work activities contributed, then the injury is compensable.

- The presenting signs or symptoms that are consistent or inconsistent with the occupational exposure and the disease
- The medical literature, including epidemiological or toxicological studies and case reports that indicate that the disease in question is associated with the worker’s exposure or occupation.

Much of this information can be obtained by taking a thorough occupational history and discussing the actual work processes with the injured worker. Because of the long latencies involved in many occupational diseases, there may be no records on the period in which the injured worker was exposed. However, the treating and evaluating physicians should attempt to obtain all available records and include them in the case documentation.

Occurring in the Course of Employment (COE)

The question of whether an injury occurred in the course of employment is not a medical question because it involves the circumstances of the accident or exposure. If COE is in dispute, a workers’ compensation judge will decide the issue based on evidence offered by the employee, the employer, or other witnesses and on legal precedents. A physician’s only input is information that helps to establish the facts of the exposure. For example, if the employer contends that the worker has changed the description of the way in which an accident happened, the physician may be asked to provide the description the worker provided on the first visit. For treating physicians, it is important to fill out the “history” section in the Doctor’s First Report with as much detail as possible (see Chapter 11 for more information). The physician may be asked whether the injuries observed were consistent with one (or both) of the conflicting histories of the incident.

The Workers’ Compensation Appeals Board (WCAB) and the California appellate courts have established that activities that are not part of the worker’s job description but are “incidental” to the employment are included in the “course of employment.” For example, employees who travel on

Box 3-5. Proximate Cause

In *Albertson's Inc. v. WCAB (Bradley)*, 131 Cal. App. 3d 309, 47 CCC 460 (1982), the court stated that subjective stress by itself was not sufficient to implicate the employment where, in fact, the employment in no way contributed to the stress that the employee was feeling. Even though the court found in favor of the employee, it ruled that there had to be something more than imagined stress. The court held under the proximate cause requirement of Labor Code § 3600(a)(6) that "The employment itself must be a positive factor influencing the course of disease."²

behalf of their employer are generally covered by workers' compensation for the entire travel period, unless there is "substantial deviation" from the agreed-upon route. Injuries sustained in employer-owned parking lots, in the restroom, or while the employee is on the premises for a rest break or lunch period are usually compensable under workers' compensation.

In a contested case, a workers' compensation judge will consider evidence on AOE and COE in the determination of compensability. It is possible for the physician to offer good evidence regarding the relationship between an exposure and the injury and for the judge to find that the injury did not occur in the course of employment. For example, consider an employee in a radiator repair shop who develops a primary motor neuropathy. The physician finds elevated blood lead levels consistent with the neuropathy and consistent with the use of lead solder in the patient's workplace. The employer contests the claim and submits evidence that the employee did not work in the shop area, that there was no lead contamination in the employee's work area, and that the employee had significant lead exposure at home, where he poured his own lead bullets at least six times per month. The judge might find that although the neuropathy appeared to be related to lead exposure, the lead exposure did not occur at work.

Presumptions about Work-Related Injuries for Certain Groups of Employees

The law defines specific conditions (e.g. hernias, pneumonia, tuberculosis, heart disease, and cancer) as work related when they affect certain employees, including firefighters, forestry officers, peace officers, and correctional employees. In these workers, the specified medical conditions are presumed to "arise out

of and in the course of the employment." These presumptions generally cover conditions that manifest or develop during the period of active service and following termination of service for up to five years

(Labor Code §§ 3212–3213.2). The laws include a **rebuttable presumption** (an assumption that can be contradicted by providing evidence to the contrary) that those conditions are employment related. The effect of this presumption is to shift the burden of proof to the employer, who must then show that the condition is not caused by work. If the employer does not meet that burden,

² A WCAB panel decision distinguished the facts in *Albertson's* from cases in which the worker has an "after-the-fact realization" of his or her injury. The panel concluded that an applicant's misperception of the cause of his physical injury is not the test of whether the physical injury was industrially caused or aggravated and should not be the test of whether a psychological consequence of that injury is compensable. The applicant must demonstrate that there was actually something in the work place that caused or contributed to the physical condition that caused the psychiatric disability (*Brannen v. SCIF* (1995) 23 CWCRC 138).

Box 3-6. Case Example: Derivative Psychiatric Injuries

The threshold for causation is different when the psychiatric injury derives from an underlying physical injury (psychiatric overlay). Rebelo injured her back in 1996 while working at Washington Hospital. The claim was accepted, and Rebelo was in a vocational rehabilitation plan in 1997, when she was hospitalized because of suicidal ideation. The employer denied having liability for the psychiatric injury. Rebelo argued that the psychiatric injury was a “compensable injury.” The judge found that actual events of employment were not a predominant cause of the psychiatric injury. The WCAB reversed the judge, stating in its decision that Labor Code § 3208.3(d) allows a psychiatric overlay to be a compensable consequence of an orthopedic injury, provided there is substantial evidence on the issue. *Rebelo v. Washington Hospital* (1999) 27 CWCR 159.

workers’ compensation benefits must be awarded. The presumptions apply only to the specific statutory disability, however, and cannot be used for other disabilities.³

Compensation for Psychiatric Injuries

Labor Code §3208.3 defines the threshold for causation for psychiatric injuries. A psychiatric injury is compensable if it is a diagnosed mental disorder that causes disability or need for medical treatment, and the employee can demonstrate that the events of employment were the “predominant cause” of the injury. The law limits workers’ compensation psychiatric claims by establishing this “higher threshold of compensability” for such claims, and by limiting the types of claims that can be submitted.⁴ These limits are summarized below.

- An injured worker must prove that the “actual events of employment” were the “predominant cause” (presumed to be more than 50%) among all the combined causes of the psychiatric injury. If the psychiatric injury is derivative of an underlying physical injury, there is no requirement for predominant cause or the psychiatric component (see Box 3-5).
- For psychiatric injuries that result from a violent act or from direct exposure to (i.e., observation of) a significant violent act, the actual events of employment must have been a “substantial cause” of the injury in that they contributed at least 35% of the causation from all sources combined.
- A psychiatric injury is not compensable unless the employee was employed by the employer for at least six months, which need not have been continuous. This requirement does not apply if the injury was caused by a sudden and extraordinary employment condition.
- Claims for psychiatric injuries that are *substantially* (at least 35%) caused by “lawful, non-discriminatory, good faith personnel actions” are prohibited. This prohibition is meant to eliminate claims that were filed by workers who suffered stress resulting from personnel actions, such as being passed over for promotion or being transferred to another department.
- Claims filed after notification of termination or layoff (see below) are prohibited.

³ In *Gurich v. WCAB* (1996) 61 CCC 1205, a deputy sheriff was prohibited from using the presumption for his heart condition under Labor Code § 3212 and applying it to his claim for psychiatric disability.

⁴ *Hansen v. WCAB* (1993) 18 Cal App 4th 1179. “It is the intent of the Legislature in enacting this section to establish a new and higher threshold of compensability for psychiatric injury under this division.”

Perception Is Not Disability

The test to be applied in cases of alleged employment stress has been held to be subjective. The proper focus of injury, then, is not on how much stress **should** be felt by an employee in the work environment, based on a normal reaction to it, but how much stress **is** felt by an individual worker reacting uniquely to the work environment. The stress, however, must still have proximately caused the injury. Proximate cause in workers' compensation is the causal connection between the injury and the employment. The employment need not be the sole cause of the injury but merely a contributing cause.⁵

How to Determine Causation for Psychiatric Injuries

Because workers' compensation psychiatric claims are subject to more restrictions, and because psychiatric claims require the collection of many additional facts, the physician must take a much more detailed history when doing this kind of evaluation. The examiner needs to address issues such as the employee's developmental history, personal problems, job satisfaction, performance reviews, and reasons for leaving other positions. A psychiatric history should include the employee's level of functioning in home, academic, and social settings. Determining whether there is workplace causation for psychiatric injuries is basically subjective; the examiner will have to rely on depositions, co-workers' statements, personnel records, psychometric test data, academic and military records, and interviews with family members. Because the examiner must review this additional data and determine the employee's potential exaggeration or minimization of symptoms, motivation for retraining, and sources of secondary gain, the psychiatric examination will take longer than a simple medical examination.

What Happens If a Claim Is Filed after Notice of Termination or Layoff?

Under Labor Code § 3208.3(e), psychiatric injuries and claims filed after notice of termination or layoff/termination are not compensable unless the actual events of employment were the predominant cause and any of the following conditions are met:

- The injury was the result of sudden and extraordinary events of employment.
- The employer had notice of the injury before the notice of termination or layoff.
- Medical records existing before the notice of termination or layoff contain evidence of treatment of the psychiatric injury.
- A contractual, administrative, regulatory, or judicial trier of fact (judge, referee, or other individual who hears and makes decisions on a case) has found that there was sexual or racial harassment.
- There is evidence that the DOI is subsequent to the date of notice of termination, but before the effective date of the termination. This provision allows post-termination claims for cumulative injuries or occupational illnesses that do not manifest themselves until after the employee has left the job. The DOI in these cases is the date when the employee first suffered disability from the exposure and either knew, or, in the exercise of reasonable diligence, should have known that the disability was caused by present or prior employment.

⁵ Maher v. WCAB (1983) 48 CCC 326.

Chapter 3

If termination or layoff does not occur within 60 days of the notice, then the prohibition against post-termination claims does not apply. Frequent notices of termination or layoff are considered a “bad-faith” personnel action and are exempted from this prohibition. Teachers and other certificated employees are not considered to have been provided with notice of termination until the school district has made a final decision not to re-employ them.

Chapter 4

Participants in the System

Key concepts:

- Employees
- Employers
- Insurance Carriers
- Claims Administrators
- Physicians
- Attorneys

Employees

As the California workers' compensation system has evolved, required coverage has been expanded to include all employees, including farm workers, many domestic and household employees, and state prison inmates in some instances. Federal, maritime, longshore workers, and railroad employees are covered under separate systems.

To receive compensation, an employee who sustains a work-related specific injury, occupational illness, or cumulative trauma must inform the employer about the injury or illness within **30 days** of the date of injury. The employer must furnish the employee with an [Employee's Claim for Workers' Compensation Benefits \(DWC 1\)](#) claim form within **one working day** of learning of the injury. The employee's claim is initiated after the employer learns of the injury from any source. The employee must complete and return the form to the employer. A dated copy must be provided to the employee.

Employees have the right to **predesignate** a personal physician to provide treatment in the event of an occupational illness or injury. Chapter 6 contains additional details on predesignation.

If the employer or the employer's insurer does not have an MPN, employees may be able to change their treating physician to their personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, employees must give their employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. If no personal physician has been predesignated, the claims administrator generally has the right to select the treating physician within the first 30 days after the employer knows about the injury or illness. After the claims administrator has initiated employees' treatment with another doctor during this period, the employees may then, upon request, have treatment transferred to their personal chiropractor or acupuncturist.

Note: If the DOI is January 1, 2004, or later, a chiropractor cannot be the treating physician after the first 24 chiropractic visits unless the employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. After 24 chiropractic visits, if the employees still requires medical treatment, then they will have to select a new physician who is not a chiropractor. This prohibition does not apply to visits for postsurgical physical medicine visits prescribed by the surgeon or physician designated by the surgeon, under the postsurgical component of the DWC's evidence-based medical guidelines (see Chapter 7).

Employers

Employers are obligated to:

- Provide a safe and healthful workplace for their employees
- Carry insurance to meet their obligations under workers' compensation law or to provide the DIR with proof of self-insurance
- Provide information about workers' compensation to their employees, including information on where and how to file a claim and on how to predesignate a personal physician
- Maintain records of occupational injuries and diseases
- Report immediately to the Division of Occupational Safety and Health (DOSH), better known as Cal/OSHA, any death or serious injury. A serious injury is defined as an injury that results in more than 24 hours of hospitalization for something other than observation, loss of a body part, or any serious degree of disfigurement.
- Provide the claim form (DWC 1) within one working day of the employer's knowledge of the injury
- Complete an [Employer's Report of Occupational Injury or Illness \("Employer's First Report" Form 5020\)](#), within five days of being notified by the employee of an occupational injury or illness. Insured employers must send the completed form to their insurer, and self-insured employers must send the form directly to the Division of Labor Statistics and Research.

Employers are prohibited from:

- Discriminating against workers for their health and safety activities or for filing a workers' compensation claim
- Terminating an injured worker during the period of temporary disability, unless the employer can prove that the termination was due to a "business necessity"
- With few exceptions (which may include legal, nonmedical, and business necessity reasons), an employer cannot refuse to reinstate an injured worker, unless the worker can no longer perform the essential functions of the job or based on a medical opinion that provides reasonable fear of re-injury. The Americans with Disabilities Act and the California Fair Employment and Housing Act place further responsibilities on the employer to provide reasonable accommodations for individuals with disabilities and prohibit discrimination based on an employee's prior involvement in any workers' compensation claim.

Insurance Carriers and Claims Administrators

In the workers' compensation system, the insurer acts on behalf of the employer and assumes most of the liability for the insured employer making benefit payments, collecting medical records, reimbursing for medical expenses, and, in some cases, paying penalties. Insurers cannot assume liability for some penalties, however, such as the penalty for serious and willful misconduct by the employer. Insurers are required to provide employers with written notice before canceling policies. They must also give employers an opportunity to present evidence when they wish to contest a claim.

Insurers employ claims administrators and other personnel to administer claims. In the majority of claims, claims administrators who make key decisions about the payment of benefits are important recipients of any physician's report about a worker's injury. Self-insured employers may elect to manage their own claims, or they may hire third-party

administrators (TPAs) to manage their caseload. Many insurers also employ medical case managers who assist the insurance carrier or payor in managing medical and other aspects of the case, including attending physician's appointments, making contact with the employee, having knowledge of the injured worker's job description, and participating in return-to-work arrangements. Their major role is providing a communication conduit between the parties (employer, insurance carrier, physician, and injured worker). Increasingly, employers/insurers perform or contract for bill review or utilization review to assist in medical cost containment and management.

Claims Administrator

Claims administrator is the term for both the insurance companies and the individuals responsible for managing the workers' compensation claim. Most individual claims administrators work for insurance companies or TPAs handling claims for employers. Some claims administrators work directly for large employers that handle their own claims. Individual claims administrators are also referred to as the "claims examiner" or "claims adjuster." Workers' compensation claims administrators are required to meet minimum training and experience requirements to practice in California.

Typical tasks of a workers' compensation claims administrator include:

- Determining liability based upon the physician's report and other factors
- Initiating and controlling delivery of accurate and timely compensation, medical and supplemental job displacement benefits as prescribed by law, including delivery of benefits and all legally required notices to all parties
- Determining whether to approve requests for medical treatment or send to utilization review
- Determining accurate and adequate estimates on assigned claims
- Reviewing and analyzing case documentation and plan proactive case management strategies
- Preparing case resumes for policyholders
- Calculating and negotiating settlements
- Writing correspondence and reports.

As stated previously, workers' compensation is a statutory benefit with no arbitrary limits on the frequency, duration, or extent of services. A claims administrator in group health must determine whether medical services fall within the contractual limits of the policy. In workers' compensation, the claims administrator must determine whether the medical services rendered are "reasonable and necessary" to "cure and relieve from the effects of an occupational injury" and whether they are likely to produce the efficient recovery of function and return to work.

Communicating with the Claims Administrator

Workers' compensation claims administrators need frequent contact with physicians because information regarding possible transitional work, job modification, return to work, and prognosis for permanent impairment is critical to the fair and efficient provision of disability payments.

This contact with the claims administrator can have real advantages for the physician by providing direct access to the person paying the bills and allowing authorization for the reimbursement of

treatment by clearing up any misunderstanding and avoiding resultant delays. It is important to remember that claims administrators have an incentive to ensure prompt and effective medical treatment so that claims are resolved as quickly as possible, but there must be clear documentation from the physician about treatment goals and progress toward those goals.

Consider the claims administrator an important resource for any technical questions relating to the workers' compensation aspect of the claim. Clear and timely communication and response to any requests by the claims administrator are critical to the success of the claim: the injured employee's prompt access to appropriate care, benefits, and return to work and health.

Other Providers of Medical Goods and Services

Other providers of medical goods and services are those that provide services that are reasonably required to cure or relieve the injured worker from the effects of his or her injury, including clinical laboratories, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, outpatient surgery, diagnostic imaging goods or services, or pharmacy goods and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, such as orthotic and prosthetic devices and services..

Physicians

Physicians play a critical role in the evaluation and care of injured workers. Their evaluations, plans, and reports form the basis for the provision of workers' compensation benefits. For a full discussion of the role and duties of the physician, see Chapter 6.

Attorneys

Any party involved in a workers' compensation claim (including lien claimants) may be represented by an attorney. Insurance companies and self-insured employers usually have litigation units in which **defense attorneys** defend the claims made against the insurer. If an injured worker hires an attorney, that attorney is known as the **applicant's attorney**.

The fees that an applicant's attorney can charge an injured worker are generally limited to a percentage of an employee's award and are determined by the workers' compensation judge or WCAB when the claim is decided. Attorneys are compensated by fees deducted from the worker's award of benefits, typically from permanent disability, unless the WCAB decides that no compensation is payable. Attorney fees may also be awarded from an employee's retroactive temporary disability award or as a separate fee following an award of a penalty against an employer for unreasonable delay or refusal to pay compensation. An attorney may also be paid for appearing at an employee's deposition when set by the employer.

Attorneys and physicians are prohibited from taking fees from injured workers on their claim without an order from the Appeals Board. Hearing representatives (who are not licensed through the State Bar of California) may also represent a party before the Appeals Board but may not receive an award for attorney's fees from the Board for their work. They must also notify the WCAB in writing that they are not licensed attorneys.⁶

⁶ *Longval v. WCAB* (1996) 61 C.C.C. 1396.

Chapter 5

Benefits and Payments to Employees

Key concepts:

- Payment for Medical Treatment
- Temporary Disability Payments
- Permanent Disability Payments
- Supplemental Job Displacement Benefits
- Death Benefits

The California Constitution (Article XIV, Section 4) states that a complete system of workers' compensation must include "adequate provisions for the comfort, health and safety and general welfare of any and all workers and those dependent upon them for support to the extent of relieving from the consequences of any injury or death incurred or sustained by workers in the course of their employment, irrespective of the fault of any party."

The California Constitution also states that the system must include "full provision" for:

- Securing safety in places of employment
- All medical, surgical, hospital, and other treatment reasonably necessary to cure or relieve the effects of injuries and illness
- Adequate insurance coverage and alternate means of securing liability, including regulation of insurance coverage and management of a state compensation insurance fund
- Vesting power, authority, and jurisdiction in an administrative body that can determine disputes, "to the end that the administration of such legislation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character, all of which matters are expressly declared to be the social public policy of this State" (California Constitution, Article XIV, Section 4)

The workers' compensation system provides the following six types of benefits to injured workers.

Medical Treatment

Medical treatment is an important benefit to workers in the system. Treatment must be provided by an employer that is reasonably required to "cure or relieve" from the effects of the industrial injury. This statutory mandate includes a wide range of treatments in various specialties and has been broadly interpreted by the courts. Employers have an obligation to authorize medical treatment up to \$10,000 within one working day after the claim is filed. If the employer fails to provide the necessary treatment, a worker may self-procure treatment, with the WCAB retaining jurisdiction over reimbursement. The benefit includes both treatment that is needed currently and treatment (including nursing services, medications, hospital services, and surgery) that may be required in the future even after the claim has been settled. It also includes interpreter services related to the treatment.

Temporary Disability Payments

Temporary disability (TD) payments are paid to the worker while the injury is being treated. When workers are unable to perform any work, they receive temporary total disability (TTD) benefits. If workers work less than their full schedule, they can receive temporary partial disability (TPD) payments. These payments are based solely on wage loss. There must be an actual wage loss in every case (i.e., if full wages are paid, no TDP is due). The following points are worth noting.

- Temporary disability is not paid to injured workers for the first three days of missed work unless they are hospitalized or miss more than 14 days of work.
- Payments must begin within 14 days of the employer's knowledge of the claim and disability, unless the employer contests the claim. The employer has 90 days from the notification of the injury to contest the claim.
- The payments are equal to two-thirds of the employee's average weekly earnings at the time of the injury, up to a ceiling determined by the legislature. The [current minimum and maximum payments](#) are listed on the DWC website. TD for an injury may last up to 104 weeks within five years from the DOI for dates of injury from January 1, 2008, to the present; for dates of injury from April 19, 2004, to December 31, 2007, 104 weeks commencing from the first date TD is actually paid; before April 19, 2004, 240 weeks or more. The TD limit is extended to 240 weeks within 240 weeks of the DOI for injuries involving certain chronic or severe conditions, including hepatitis B and C, amputations, severe burns, HIV, chemical eye burns, pulmonary fibrosis, and chronic lung disease.
- These replacement wages are not taxable.
- If there is estimated wage loss, TPD payments are equal to two-thirds of the estimated wage loss (e.g., if the employee is paid a lower wage or works fewer hours because of the temporary disability).
- Full-time workers may face huge earnings losses when they are receiving workers' compensation benefits. Disability payments can vary from 50% (or less) to 66% of a worker's wage. The benefits that can be paid have a ceiling; accordingly, the impact of lost wages will be higher for a worker who earns a higher salary.
- Income from work outside the regular job does not affect TD payments.

Permanent Disability Payments

Permanent disability (PD) payments are to compensate an employee who does not completely recover from an injury. They are based on a worker's prospective loss of earning power in the overall job market. Under California law, the amount is determined according to the percentage of disability. The [current minimum and maximum payments](#) are listed on the DWC website.

- For total disability (100%), the employee will receive the weekly amount that was determined for temporary disability for life.
- For partial disability (up to 99.75%), the employee receives weekly payments for a number of weeks determined by the employee's disability rating.
- For dates of injury between January 1, 2005, and December 31, 2012, if within 60 days of when the injury became permanent and stationary, an employer does not offer the employee regular work, modified work, or alternative work in the form and manner prescribed by the AD for a period of at least 12 months, each remaining disability payment from the date

of the end of the 60 days shall be increased by 15%. If within 60 days of when the injury became permanent and stationery, an employer does offer the employee regular work, modified work, or alternative work in the form and manner prescribed by the AD for a period of at least 12 months, and regardless of whether the employee accepts or rejects the offer, each remaining disability payment from the date the offer was made shall be decreased by 15%. The 15% increase applies to employers who employ 50 or more employees (Labor Code § 4658(d)).

- Workers with permanent partial disabilities of 70% or more continue to receive a small pension for life after their permanent disability amount is exhausted.

Supplemental Job Displacement Benefits

Workers injured on or after January 1, 2004, are eligible for a supplemental job displacement benefit (SJDB) voucher. *The benefit amount varies by date of injury, as described below.*

Employees injured between January 1, 2004, and December 31, 2012, with injuries that result in permanent partial disability and who do not return to work for the employer within 60 days of termination of temporary disability may qualify for the SJDB voucher, unless the employer offers and the employee rejects, or fails to accept, modified work lasting at least 12 months. The benefit comes in the form of a nontransferable voucher that can be used to pay for education-related retraining or skill enhancement, or both, at state-approved or state-accredited schools. The voucher covers school tuition, fees for books, and expenses required by the school for training. No more than 10% of the value of the voucher can be used for vocational and return-to-work counseling. The amount of the voucher varies from \$4,000 to \$10,000, depending on the level of permanent disability. The current voucher amounts are:

- | | |
|--|-------------------|
| • For permanent disability of less than 15% | \$4,000 voucher |
| • For permanent disability between 15% and 25% | \$6,000 voucher |
| • For permanent disability between 26% and 49% | \$8,000 voucher |
| • For permanent disability between 50% and 99% | \$10,000 voucher. |

Employees injured on or after January 1, 2013, with injuries that result in permanent partial disability, and whose employer does not offer other regular, modified, or alternative work, may also qualify for the SJDB voucher. The offer must be made within 60 days after receipt by the claims administrator of the [Physician's Return to Work & Voucher Report \(Form DWC-AD 10133.36\)](#). The voucher amount is \$6,000 for all levels of permanent disability and can be used for training at a California public school or any other provider listed on the list of the state's eligible training providers. 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 valued at up to \$1,000, and to reimburse up to \$500 in miscellaneous expenses. Up to 10%, or \$600, may be used to pay for the services of a licensed placement agency or vocational counselor. No more than 10% of the value of the voucher can be used for vocational and return-to-work counseling.

Return-to-Work Fund

A return-to-work program of \$120 million annually derived from fees paid by employers into the Workers' Compensation Administration Revolving Fund is administered by the AD (Labor Code § 139.48). The purpose of these funds is to make supplemental payments

to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss. Eligibility for payments and the amount of payments are determined by regulations adopted by the AD, based on findings from studies conducted in consultation with the Commission on Health and Safety and Workers' Compensation. Determinations by the AD are subject to review at the trial level of the WCAB.

Death Benefits

Death benefits are payments to a spouse, the children, or other dependents if an employee dies from a work-related injury or illness, including reasonable burial expenses, not exceeding \$5,000 for injuries before January 1, 2013, and \$10,000 for injuries on or after January 1, 2013. Following an employee death, the amount of the death benefit depends on the number of their total or partial dependents. In the case of one or more totally dependent minors, after payment of the amounts specified below, death benefits will continue until the youngest minor's eighteenth birthday (for DOI after January 1, 1990; for DOI after January 1, 2003, disabled minors receive benefits for life). Death benefits are paid at the total temporary disability rate, but not less than \$224.00 per week. The period within which proceedings commence for the disbursement of death benefits is one year from the date of death when it occurs within one year of the DOI, or one year from the date when the last benefits were disbursed, or one year from death when it occurs more than one year from the DOI. No such proceedings may be commenced more than 240 weeks from the DOI. [Current death benefit rates](#) are listed on the DWC website.

Initiating Benefits: Employee, Employer, and Physician

The following employee and employer reports are required to initiate benefits and payments to injured workers. To receive compensation, an employee who is injured on the job or develops a work-related illness must inform the employer about the injury or illness within 30 days of the DOI. The employer must furnish the worker with a claim form ([Employee's Claim for Workers' Compensation Benefits, DWC 1](#)), within one working day of learning of the injury. The employee's claim is initiated after the employer learns of the injury from any source. The worker must complete and return the form to the employer. A dated copy must be provided to the worker. Unless an employee has predesignated a personal physician, the employer directs the injured worker to a particular physician for at least the first visit.

Treating physicians play an important role in ensuring that injured workers receive appropriate benefits in a timely fashion. Physicians must complete reports that will affect the provision of benefits to injured workers, including the Doctor's First Report, progress reports, and medical-legal evaluations, all of which are used to establish the worker's eligibility for benefits and to resolve disputes over treatment, disability, and other issues. See Chapter 7 for detailed information.

Discrimination Not Allowed

Employers are prohibited from discriminating against workers because of their health and safety activities or filing a workers' compensation claim. Employers may not terminate an injured worker during the period of temporary disability, unless the employer can prove that the termination was due to a "business necessity." With few exceptions, an employer cannot refuse to reinstate an injured worker, unless the worker can no longer perform the essential functions of the job. The Amer-

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icans with Disabilities Act and the California Fair Employment and Housing Act place further responsibilities on the employer to provide reasonable accommodations for individuals with disabilities and prohibit discrimination based on an employee's prior involvement in any workers' compensation claim.

Chapter 6

The Role/Duties of the Physician

Key concepts:

- Primary Treating Physician
- Secondary Treating Physician
- Medical Provider Networks
- Health Care Organizations
- Predesignated Physician
- Self-Referral and Cross-Referral
- Physician and Psychological Assistants, Nurse Practitioners

The California workers' compensation system utilizes several types of physicians. In addition to primary treating physicians and secondary physicians, QMEs, AMEs, and consulting physicians also play a role. Physicians provide medical care for injured workers and write reports that are critical to the continuation of care provided to the injured worker.

Physicians provide crucial input for the system.

- Physicians define the injury and establish whether and how the injury is related to the employment.
- Treating physician reports and medical-legal evaluations are used to establish the worker's eligibility for benefits and to resolve disputes over treatment, disability, and other issues.
- It is important for the treating physician to understand these complex roles and how exams, records, and reports can affect the lives of patients. The primary treating physician's reports, if accurate, complete, and timely, can help avoid costly litigation and can prevent delays in the delivery of benefits to patients.
- The primary treating physician must cooperate with the parties in the workers' compensation system by providing information in a timely manner. When a physician does not complete paperwork on time, the injured worker's benefits can be delayed. Many injured workers have no source of income other than their workers' compensation disability benefits, so a delay in these benefits can cause considerable hardship.

Primary and Secondary Treating Physician

Primary Treating Physician

A **primary treating physician (PTP)** is the physician, in the employer's MPN, HCO, or predesignated by the employee, 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 for an occupational injury or illness and has monitored the effect of the treatment thereafter.

The duties of PTPs in accepted claims are:

- Treating patients and communicating a treatment plan to the payor
- Providing a first report of work injury at the time of the initial contact and progress reports thereafter (see Chapter 7)

- Determining the nature and duration of temporary disability
- Determining work restrictions
- Determining medical eligibility for vocational rehabilitation services (for injuries prior to January 1, 2004)
- Releasing patient to return to work
- Determining when the patient's condition is permanent and stationary
- Conducting the initial permanent disability evaluation, if the patient has not recovered fully
- Obtaining all the reports of secondary physicians and incorporating or commenting upon their opinions
- Writing or consolidating reports
- Providing copies of reports to the appropriate parties.

Secondary Treating Physician

A **secondary physician** is any physician other than the PTP who examines or provides treatment to the employee but is not primarily responsible for continuing management of the care of the employee.

The duties of secondary physicians are:

- Examining or providing treatment to the injured employee but without primary responsibility for continuing management of the care of the injured employee
- Reporting as necessary to the PTP.

How a Physician Becomes Part of Caring for Injured Workers

A physician may participate in the care of injured workers in several ways: (1) as a member of an MPN assembled by an employer, an insurer, or an entity that provides physician network services; (2) as a member of an HCO that has been designated to care for employees injured at work; or (3) as a treating physician freely selected by an injured employee if the employer or the insurer of an employer has not entered into an arrangement with an MPN or an HCO (the employer has the right to designate where the injured employee may obtain initial treatment and treatment for the first 30 days after an injury).

Medical Provider Networks (MPNs)

An MPN is a network of providers established by an employer, an insurer, or an entity that provides physician services to treat employees with work-related injuries.

An MPN must be approved by the DWC's AD to treat workers injured on the job. Under state regulations, each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general medicine. MPNs are required to meet standards for access to care for common occupational injuries and work-related illnesses. The MPN regulations allow employees a choice of providers in the network after the employee's first visit. Additionally, MPNs must offer an opportunity for second and third opinions if an injured worker disagrees with the diagnosis or treatment offered by the treating physician. If a disagreement still exists after the second and third opinion, an injured worker in the MPN may request an MPN independent medical review (MPN-IMR). California's workers' compensation system has two separate and distinct IMR processes. The IMR process involving MPN physicians is strictly bound by MPN regulations for disputes regarding

Box 6-1. MPN Changes under SB 863

Significant changes affecting MPNs triggered by Senate Bill 863 (2012) include the following:

For new MPN applicants:

- An entity that provides physician network services can now also apply to be an MPN applicant.

For established MPNs:

- As of January 1, 2013, a contracting agent must inform MPN providers entering or renewing a provider contract that they are part of an MPN whether their contract is sold, leased, transferred, or conveyed to another MPN applicant, contracting agent, or workers' compensation insurer.
- Medical access assistants are required for each MPN to assist workers with finding available MPN physicians and contact physicians' offices for appointments and must be available from 7 am to 8 pm Pacific Standard Time, Monday through Saturday, through a toll-free number.
- Four-Year Approval: MPN plans will be approved for four years, as of January 1, 2014.
 - Applications for re-approval of existing plans must be submitted six months prior before the expiration of four-year approval;
 - Geocoding of provider listings is required for re-approval;
 - Quality assurance processes must be established for MPNs.
- MPN physicians need to acknowledge that they have elected to be part of the MPN, as of January 1, 2014.
- Each MPN is required to have a website and access to their provider listing on their website, as of January 1, 2014:
 - The provider listing must AD Director must post website addresses for approved MPNs

an MPN physician's diagnosis or treatment. The second IMR process is regulated under Labor Code §4610.5 and is strictly for medical treatment due to medical necessity after a utilization review denial, modification, or delay determination.

The MPN regulations also require proper notification to employees about their medical coverage, procedures to be followed when an employer changes its MPN coverage, ceases or terminates the use of an MPN, or transfers care of an injured employee under an MPN. Law and rules pertaining to MPNs are covered in Labor Code §§ 4616-4616.7 and 8 CCR §§ 9767.5 et seq.

The establishment of an MPN gives employers significant medical control. With the exception of employees who have predesignated a physician, employers that have established an MPN control the medical treatment of employees injured at work for the life of a claim. Having an MPN means the employer *also* has more control with regard to which providers are in the network and whom the injured worker sees for care. The employer chooses the injured worker's PTP for the first visit; after the first visit, the injured worker may choose any physician in the MPN.

Since its inception in 2005, the MPN program has continued to expand as more MPNs are utilized (see Box 6-1). As of 2014, the DWC began not only to approve but also to monitor MPNs. As of November 2015, California had about 2,300 MPNs. There is no readily available information regarding the number of California physicians who are members of MPNs, the number of physicians who are in one or more MPNs, the organizational and economic structures of the various networks, or the medical oversight of various networks.

For information about joining an MPN, please read the [memo to healthcare providers](#) on the [DWC website](#).

Health Care Organizations (HCOs)

HCOs were created by workers' compensation reforms in 1993. HCOs are managed care organizations established to provide health care to employees injured at work.

The DWC reviews applications from HCOs and certifies them for the delivery of medical treatment under California workers' compensation law. Three types of organizations may apply for HCO certification: health maintenance organizations (HMOs) licensed by the California Department of Managed Health Care, disability insurers licensed by the Department of Insurance, and workers' compensation health care provider organizations (WCHCPOs) authorized by the AD of the DWC. Certification requirements for HCOs are listed in Labor Code §§ [4600.3-4600.6](#) and 8 CCR §§ [9770-9779.8](#).

Self-insured employers and insurers may contract with an HCO to provide medical and disability management services to injured workers. Employees must be provided a choice of at least one HCO, and an open enrollment process is required that allows employees to predesignate their own personal physician, personal chiropractor, or personal acupuncturist.

HCOs must include a comprehensive health-care delivery system, including assignment of PTP, consultation and referral, inpatient hospital care, emergency services, diagnostic facilities, home health services, a quality assurance and medical case management system, return-to-work coordination, consultation on health and safety, and data reporting.

Employers who contract with an HCO can direct treatment of injured workers up to 90 or 180 days following an injury, depending on the contribution of the employer to the employees' non-occupational health care coverage. After 90 or 180 days, an employee may choose to continue care in the HCO or obtain care outside the HCO. An employee who is under treatment in an HCO may change treating physicians once.

Regardless of whether care is provided to an injured employee within an HCO, the treatment of an injured worker must follow all medical treatment guidelines established by the DWC.

At its peak in 2004, HCO enrollment reached approximately half a million enrollees. However, after the enactment of MPNs, the enrollment of employees in the large HCOs declined considerably.

The DWC maintains a list of certified HCOs. [Physicians interested in joining an HCO should apply directly with the entity.](#)

Care outside MPNs and HCOs

Under special circumstances, a physician who is not a member of the network or organization used by an employer may arrange to care for an injured worker—for example, when the specialty of the physician is not one ordinarily found in an MPN or an HCO or the employer has agreed to care by the physician.

In general, an employer is not responsible for medical care that an employee obtains outside the employer's MPN or HCO. If the employer does not have an established MPN or HCO, the employee is free to select a physician and has the right to receive reports as required in the treatment of injured workers and to review and authorize medical treatment to ensure it is consistent with established guidelines.

Predesignated Physician

An employee who predesignates his or her treating physician is able to obtain treatment outside the employer's HCO or MPN, regardless of whether the predesignated provider is a member of the employer's HCO or MPN.

In the event that an employee sustains an injury or illness related to employment, the employee may be treated for this injury or illness by the employee's personal medical doctor (MD), doctor of osteopathic medicine (DO), or medical group if:

- The employer offers group health coverage.
- The doctor is the employee's regular physician, either a physician who has limited his or her practice of medicine to general practice or someone who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner and has previously directed the employee's medical treatment and retains the employee's medical records;
- The "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.
- Prior to the injury, the employee's doctor agreed to treat an individual for work injuries or illnesses.
- Prior to the injury, the employee provided the employer with the following in writing: (1) notice that the employee wished his or her personal doctor to provide treatment for a work-related injury or illness, and (2) the personal doctor's name and business address. The [form](#) to notify an employer of an employee's choice of a personal medical doctor or a doctor of osteopathic medicine provide treatment for a work-related injury or illness can be submitted if the above requirements are met.

The predesignated physician is expected to follow the rules required for the treatment of injured workers, including timely reporting and acceptance of the workers' compensation fee schedule that applies to the California workers' compensation system and to provide treatment consistent with medical treatment guidelines. Physicians to whom a predesignated physician makes referrals are covered by the same rules.

The law requires that every employee be given an affirmative choice at the time of being hired and at least annually thereafter to designate or change the designation of his or her HCO or a personal physician, personal chiropractor, or personal acupuncturist. An employee who has predesignated a personal physician, personal chiropractor, or personal acupuncturist may change the designated caregiver at any time prior to injury. Any employee who fails to predesignate a personal physician, personal chiropractor, or personal acupuncturist will be treated by the HCO or MPN selected by the employer.

Self-Referrals and Cross Referrals

Treating or evaluating physicians for injured workers may not self-refer and are required to include a declaration on all bills that they are not in violation of the self-referral law as set forth in Labor Code § 139.3. Most physicians include this statement in their declaration that the contents of the report are true and correct to the best of their knowledge. Some forms contain this declaration and

Box 6-2. Violation of Labor Code § 139.3

In *Jones v Target Stores* (1998) 26 CWCR 319, the Appeals Board, in a significant panel decision, held that failure by a physician to obtain preauthorization for a physical therapy referral to the clinic that employed him was a violation of Labor Code §139.3(e). The panel found that the referring physician was not in violation of the self-referral laws because he was on a flat salary and received no compensation for referrals to the clinic at which he worked. Because the referral was for physical therapy, however, the referral was disallowed by the board because there was no preauthorization (Labor Code §139.31(e)).

medical-legal reports prepared by QMEs are also required to include this language in their reports (see Chapter 11).

The Labor Code and the Business and Professions Code now contain more comprehensive provisions on self-referrals. These provisions were developed because some physicians had routinely referred patients for expensive and unnecessary diagnostic procedures at facilities in which they had a financial interest. Certain types of self-referrals (referrals to certain facilities in which the physician or the physician's family has a financial interest) are specifically prohibited. The following referrals are not allowed (with the exceptions noted below):

- Any outside referrals for the following services, in which the physician or the physician's family has a financial interest: clinical laboratories, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging; this includes any arrangement in which the referring physician receives money from the recipient facility and physician;
- Any cross-referral arrangement or other scheme whose primary purpose is to ensure referrals (Labor Code § 5307.6; Labor Code § 3215; Bus. & Prof. § 650) (e.g., if two doctors routinely refer patients to each other, even if the referrals are not always necessary);
- Any kind of compensation or inducement for referred evaluations or consultations. For example, a physician cannot buy gifts for claims examiners as an inducement to receive referrals from that insurer. It is now a felony to offer compensation to a claims adjuster for a referral (Labor Code § 3219).

Exceptions to the above are as follows:

- If a physician needs to make a referral for a nonprohibited service in which that physician has a financial interest, the physician must disclose that information to the patient. The prohibition is not intended to alter, limit, or expand a physician's ability to deliver or supervise the delivery of services or goods provided within the physician's own office or group practice;
- If the services are for physical therapy, certain psychiatric testing, or, more typically, MRIs, the physician is required to obtain preauthorization in writing within five days (Labor Code § 139.31(e)). Any violation of these referral prohibitions is a misdemeanor.
- If the physician's regular practice is outside a metropolitan area, and there are no alternatives available within 25 miles or a 40-minute drive, the physician may make referrals for

services in which the physician has a financial interest, with full disclosure to the patient and the insurer/adjuster (Labor Code § 139.31(a)).

The District Attorney's (DA's) office handles self- and cross-referral violations. Physicians with questions concerning Labor Code §139.3 should consult with an attorney or contact the local DA's workers' compensation division.

Use of Physician or Psychological Assistants and Nurse Practitioners

Under workers' compensation law, a licensed physician may employ a physician or psychological assistant or a nurse practitioner in the treatment of injured workers. These "physician extenders" **cannot determine disability**. A licensed supervising physician must review the treatment administered by the extender and sign any report. According to California law, all care given to a patient by an extender is ultimately the responsibility of the supervising physician. Current law limits a physician to supervising no more than two physician assistants (PAs) at any moment in time. The immediate availability of the supervising physician is required whenever a PA or nurse practitioner is providing direct patient care.

According to the regulations, the availability of the physician to provide the required supervision must be accomplished by being in the same facility with the PA or by being immediately available by electronic communications.

Before authorizing a PA to perform any medical procedure, the physician is responsible for evaluating the PA's education, experience, knowledge, and ability to perform the procedure safely and correctly. In addition, the physician is also responsible for verifying that a PA has a current California license issued by the Physician Assistant Board.

Lastly, the Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet the requirements of CCR, Title 16, §1399.540. The DSA is the foundation of the relationship between a supervising physician and the PA and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Chapter 7

Reports and Timelines in the System

Key concepts:

- Doctor's First Report of Occupational Injury or Illness (DFR)
- Primary Treating Physician's Progress Report (PR-2)
- Request for Authorization (RFA)
- Permanent and Stationary Reports (PR-3 or PR-4)

The California workers' compensation system requires that physicians complete specific types of reports to ensure appropriate benefits and payments to injured workers.

The PTP (or a physician designated by the PTP) is required to submit reports to the claims administrator. A PTP has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator. The PTP may transmit reports to the claims administrator (or entity designated by the claims administrator as his or her recipient) by mail or fax or by any other means satisfactory to the claims administrator, including electronic transmission (8 CCR §9785(c) & (d)).

Importance of Timely Reports

The primary treating physician must cooperate with the parties in the workers' compensation system by providing information in a timely manner. When a physician does not complete paperwork on time, benefits to the injured worker may be delayed. Many injured workers have no source of income other than their workers' compensation disability benefits so delays may cause considerable hardship.

Doctor's First Report of Occupational Injury or Illness⁷

PTPs are required to submit a Doctor's First Report of Occupational Injury or Illness (DFR, [Form 5021](#)) for **any suspected work-related injury or illness**. The DFR must be filed with the employer's workers' compensation insurer or directly with employers if they are self-insured, within five working days of an injured worker's first visit (Labor Code §6409 and 8 CCR §14003). This means that if the injured worker says that the injury is work related, the physician must complete a DFR and send it to the insurer or self-insured employer. Failure to send this form could not only delay benefits to patients and delay or prevent the physician from being paid but also result in the assessment of a civil penalty (Labor Code § 6413.5). If the patient has been referred to a specialist by the treating physician, and the treating physician has already filed a DFR, it is not necessary for the specialist to submit another DFR. However, a new PTP or an emergency or urgent care physician is required to complete the form (8 CCR § 9785 (e)(1)).

In case of a suspected or diagnosed pesticide poisoning, the treating physician must contact the local health officer within 24 hours and send a copy of the DFR to the address indicated on the [Pesticide-Related Illness form](#).

⁷ The forms referenced in this section can be found on the [DWC website](#).

Information in the Doctor's First Report

The following fields must be completed on the DFR (8 CCR § 9785(e)(1) and Form 5021):

- The name and address of the injured employee
- The employee's medical history, including any significant prior injuries or disabilities
- Examination findings, including the objective findings, the employee's subjective complaints, and the diagnosis
- The methods, frequency, and duration of treatment, including an estimated date of completion
- If appropriate, the estimated return-to-work date for regular or modified work
- An opinion as to whether residual permanent disability is to be anticipated and, if possible, an estimate of its extent
- An opinion as to whether the employee is or will eventually be able to engage in the occupation being performed at the time of injury.

Medical treatment for an occupational injury should be based upon the guidelines in the medical treatment utilization schedule (MTUS; see Chapter 8 for more information). The treatment plan should include a description of the methods, frequency, and duration of treatment and an estimated date of completion. Preparing a clear and complete treatment plan and keeping the insurance company notified of any changes (and the rationale for these changes) facilitates the provision of benefits to patients as well as prompt payment of physician bills.

Progress Reports or Other Periodic Reports

Progress Reports

The PTP is responsible for managing the employee's medical treatment and rendering opinions on all medical issues necessary to determine the employee's eligibility for compensation. As part of this responsibility, PTPs are required during periods of active treatment to file progress reports (PR-2s) with the claims administrator. Secondary physicians and other health-care providers to whom the employee is referred are required to report directly to the PTPs (8 CCR § 9785(e)(3)).

Progress reports must be submitted at reasonable intervals: at least every 45 days and within 20 days if an examination has occurred. These reports do not need to be lengthy or formal but must include an explanation for current treatment and a reasonable estimate of the method, frequency, and duration of the remaining treatment. This must be communicated in a PTP's progress report, the PR-2 form, or in a narrative report form. (By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.) **If a narrative report is used, it must be titled "Primary Treating Physician's Progress Report" in boldface, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as the PR-2 form.**

The progress report must be submitted to the claims administrator handling the case or someone designated by the claims administrator. Sending an original report to an attorney and copies to the claims administrator is not acceptable. Failure to submit progress reports in the appropriate form and manner constitutes good cause to grant a claims administrator's request for a change of the employee's PTP (8 CCR § 9786(b)).

The report is not considered complete if it does not include the current subjective and objective findings, for example, the current complaints, functional status, and response to treatment; the physical examination and any test results; an updated diagnosis; and any new or continuing recommendations for tests or treatment. The absence of this information and corresponding rationale(s) for any requests make it extremely difficult for the claims organization to properly evaluate the requests from the treating physician, which may prompt additional requests for information by the claims adjuster and result in delays in care for the injured worker. Ultimately it is the responsibility of the treating physician to communicate fully with the claims organization so that timely treatment can be obtained for the injured worker.

To avoid disputes over payment for medical services, the physician must provide a rationale for each component of the treatment plan. The physician should carefully explain the rationale and, when possible, obtain preauthorization from the insurance carrier or employer for any extraordinary or prolonged course of treatment. Treatment of the injured worker must be consistent with the treatment plan that has been submitted. An employer may have grounds to request a change of treating physician if the treatment does not follow the plan (though the employer must first provide notice of its concerns and allow a chance for correction). Treatment plan updates or revisions may be indicated in progress reports, which are periodically required, as discussed below.

Responses to requests for information from claim adjusters may be submitted in the form of a letter. A narrative report or a response to a request for information in the form of a letter must contain the same declaration under penalty of perjury, as set forth in the PR-2 form: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3."

What Events Trigger the Need for Progress Reports?

Under [8 CCR § 9785\(f\)](#), a PTP must promptly report to the claims administrator when any one or more of the following occurs:

- When ongoing treatment is provided, a progress report is required no later than 45 days from the last report of any type even if no event described below has occurred.
- The employee's condition undergoes a previously unexpected significant change.
- A significant change is made in the treatment plan reported, including, but not limited to, (1) an extension in the duration or frequency of treatment, (2) a new need for hospitalization or surgery, (3) a new need for referral or consultation by another physician, (4) a change in methods of treatment or in required physical medicine services, or (5) a need for rental or purchase of durable medical equipment or orthotic devices.
- The employee's condition permits return to modified or regular work.
- The employee's condition requires him or her to leave work or requires changes in work restrictions or modifications.
- The employee is discharged.
- After the employee's condition has become permanent and stationary, the PTP concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury.
- The employer reasonably requests additional information necessary to administer the claim.

Request for Authorization (RFA)

A treating physician is required to use the Request for Authorization (RFA) form to request treatment, diagnostic tests, or other medical services for an injured worker. If the treatment request was first made verbally, it must be confirmed in writing and be clearly marked at the top that it is written confirmation of an oral request. The treating physician must fill out the form and attach documentation that substantiates the need for the requested treatment—for example, the DFR, PR-2, or narrative report that substantiates the need for the requested treatment. The claims administrator will conduct utilization review on the treatment request under the MTUS guidelines and contact the treating physician with a decision as to whether the treatment is authorized.

Permanent and Stationary Form (PR-3 or PR-4)

When the PTP determines that the employee's condition is permanent and stationary (P&S), the physician must (unless good cause is shown) report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing or future medical care resulting from the injury. This information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" (the PR-3 form for pre-2005 injuries or the PR-4 form for injuries on or after January 1, 2005) or in such other manner that provides all the following required information ([8 CCR §10606](#)):

- the date of the examination
- the history of the injury
- the patient's complaints
- a listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion
- the patient's medical history, including injuries and conditions, and residuals thereof, if any
- findings on examination
- a diagnosis
- an opinion as to the nature, extent, and duration of disability and work limitations, if any
- the cause of the disability
- the treatment indicated
- an opinion as to whether or not permanent disability has resulted from the injury and whether it is stationary; if it is found to be stationary, a description of the disability with a complete evaluation
- an apportionment of disability, if any
- a determination of the percentage of the total causation resulting from actual events of employment if the injury is alleged to be a psychiatric injury
- the reasons for the opinion
- the signature of the physician.

Chapter 7

If the PR-4 form is used, the PTP must describe the existence and extent of permanent impairment in accordance with the *AMA Guides to the Evaluation on Permanent Impairment*, fifth edition.⁸

If the PTP finds that the employee is P&S with regard to all conditions and that the injury has resulted in permanent partial disability, he/she must also complete the “Physician’s Return-to-Work & Voucher Report” (DWC-AD 10133.36) and attach it to the “Primary Treating Physician’s Permanent and Stationary Report” form.

Note that reimbursement for a PTP’s P&S report is made according to the Official Medical Fee Schedule (OMFS) because it is not generated as the result of a dispute by the parties. Medical-legal reports, which are generated with the intent to resolve a dispute, are reimbursed according to the Medical-Legal Fee Schedule (MLFS).

⁸ The sixth edition of the AMA Guide was published in 2008; however, the fifth edition is currently relied upon for use in medical-legal determinations in the California workers’ compensation system.

Chapter 8

Evidence-Based Medical Guidelines and the Medical Treatment Utilization Schedule

Key concepts:

- California's Evidence-Based Medical Guidelines—the Medical Treatment Utilization Schedule (MTUS)
- Clinical Topics
- Functional Improvement
- Presumption of Correctness

In order to promote health and well-being effectively, health-care professionals are required to base clinical decisions on the best available evidence. Evidence-based medicine (EBM) is a systematic approach to making clinical decisions that allows the integration of the best available research evidence with clinical expertise and patient or community values. EBM is a method of improving the quality of care by encouraging practices that work and discouraging those that are ineffective or harmful. EBM asserts that intuition, unsystematic clinical experience, and pathophysiologic rationale are insufficient grounds for making clinical decisions. EBM involves using a hierarchy of evidence to guide clinical decision making.

California is a leader in promoting the use of EBM and a hierarchy of evidence for the appropriate medical management of ill and injured workers in the workers' compensation system.

Guidelines for medical treatment are created by collecting relevant medical literature, critically reviewing that literature and reaching conclusions that are supported by the medical scientific literature. The medical treatment utilization schedule (MTUS) is the set of evidence-based medical treatment guidelines that must be followed when evaluating and treating ill and injured workers. It must also be used in the utilization review process and medical dispute resolution process (IMR). The MTUS helps medical providers understand which evidenced-based treatments have been effective in providing improved medical outcomes to workers. It also includes recommendations on how often the treatment is given (frequency), extent of treatment (intensity), and for how long (duration).

The MTUS is constructed from a variety of sources, including nationally recognized, published medical treatment guidelines in their original form or revised for use in California as well as guidance developed by the DWC with input from a medical evidence evaluation advisory committee (see below). The guidelines are incorporated into the body of regulations issued by the DWC. As with all regulations issued by the DWC, the MTUS undergoes a formal rule-making process that takes public comments into account. The MTUS has been constructed in a modular fashion to allow periodic revision/updating of sections. Currently, the MTUS includes chapters from two proprietary guidelines, the American College of Occupational and Environmental Medicine (ACOEM) and the Official Disability Guidelines (ODG). Although both the ACOEM and ODG guidelines are incorporated by reference into the MTUS may be viewed by the public at no cost, it may require a visit to the nearest DWC office to access. As new ACOEM and ODG chapters are adopted, it is anticipated that they will be more accessible.

The [most recent revisions of the regulations](#) clarify the role of the MTUS as the standard of medical care for work-related illness or injury and describe two limited situations that may warrant treatment based on recommendations found outside the MTUS: (1) if the medical condition or injury is not addressed by the MTUS, or (2) if the MTUS's presumption of correctness is successfully

Box 8-1. Evidence-Based Medical Guidelines

The **DWC medical treatment utilization schedule (MTUS)** provides a framework for the most effective treatment of injured and ill workers and is based on the principles of EBM. The Strength (or Hierarchy) of Evidence guidelines use EBM-based principles to guide appropriate clinical decision making for injured and ill workers when new evidence is produced or when the MTUS does not address a clinical condition or a diagnostic test.

rebutted. The MTUS provides guidance on how to conduct a search for medical evidence for treating physicians and reviewing physicians to consistently and efficiently navigate the vast array of medical literature.

Clinical Topics

The clinical topics apply to the initial management and subsequent treatment of presenting complaints specific to the body part as set forth in 8 CCR § 9792.23.1 *et seq.* As of 2016, most of these chapters are in the process of being updated.

Ankle and foot complaints: 8 CCR § 9792.23.7

Elbow disorders: 8 CCR § 9792.23.3

Eye: 8 CCR § 9792.23.9

Forearm, wrist, and hand complaints: 8 CCR § 9792.23.4

Knee complaints: 8 CCR § 9792.23.6

Low back complaints: 8 CCR § 9792.23.5

Neck and upper back complaints: 8 CCR § 9792.23.1

Shoulder complaints: 8 CCR § 9792.23.2

Stress related conditions: 8 CCR § 9792.23.8

Special topics: 8 CCR § 9792.24.1 (applies to all the chapters)

Acupuncture medical treatment guidelines 8 CCR § 9792.24.1

Chronic pain medical treatment guidelines 8 CCR § 9792.24.2

Opioids Treatment Guidelines (in rulemaking at the time of publication)

Postsurgical treatment guidelines 8 CCR § 9792.24.3

Presumption of Correctness

The MTUS is presumed to be correct on the issue of the extent and scope of medical treatment and diagnostic services it addresses. However, the MTUS may be successfully challenged by a preponderance of scientific medical evidence of high quality that shows that a variance from the MTUS is reasonably required to cure or relieve the injured worker from the effects of his or her injury. For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services must be in accordance with other scientific, evidence-based medical treatment guidelines that are nationally recognized by the medical community.

Box 8-1. MTUS Timeline

January 1, 2004

The legislature charged the DWC AD with adopting a medical treatment utilization schedule (MTUS) that would be presumed correct on the issue of extent and scope of medical treatment and made the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM), second edition, the standard until the adoption of an MTUS by the AD.

June 15, 2007

The date the MTUS became effective. Among other provisions, the MTUS regulations incorporated the ACOEM Practice Guidelines and acupuncture guidelines. The rules also laid out a strength-of-evidence rating methodology by which specific medical treatments or diagnostic services were to be evaluated and established the Medical Evidence Evaluation Advisory Committee (MEEAC).

July 18, 2009

The MTUS was updated and added new guidelines for chronic pain and postsurgical physical medicine treatment. The MTUS was also restructured into clinical topics, designed to allow for easier updates of the guidelines.

2015

The MTUS regulations were revised and went into effect April 20, 2015. These regulations clarify the process used to evaluate medical evidence and required to be applied when there are competing treatment recommendations and a dispute about which recommendation will guide the injured worker's medical care. The most recent revision of the MTUS allow treating physicians, reviewing physicians and claims administrators to make better-informed decisions to reduce disputes over medical treatment.

Functional Improvement

The MTUS constitutes the standard for the provision of medical care in accordance with Labor Code § 4600 for all injured workers diagnosed with industrial conditions because it provides a framework for the most effective treatment of work-related illness or injury to achieve functional improvement, return-to-work, and disability prevention.

The concept of functional improvement is central to the treatment of work-related injuries and illnesses in the workers' compensation system. **Functional improvement** as defined by the MTUS means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the medical evaluation and treatment, and a reduction in the dependence on continued medical treatment.

The treating physician's assessment and documentation of functional improvement substantiates the treatment plan, guides employers on any work restrictions for return to work, and certifies the need for disability benefits due the injured worker. For these reasons, the treating physician is expected to assess and clearly document functional improvement and work status, including any restrictions, at every visit.

Delayed Recovery and Early Intervention

The following material is included to encourage treating physicians, medical-legal evaluators, and others to familiarize themselves with the important concept of “delayed recovery” and its consequences. This topic is discussed at length in the Introduction to the Chronic Pain Guideline in the MTUS.

It has been estimated that 10% of California’s workers’ compensation cases consume more than 75% of available medical and indemnity resources.

“Delayed recovery” (DR) and chronic pain (CP), the final common pathway of DR, have proven to be the major drivers of disproportionate overutilization by this subpopulation in both workers’ compensation and group health populations.

It would best serve California PTPs and medical-legal evaluators to understand the clinical characteristics of those at risk for DR/CP. Otherwise, timely referrals to assist the injured worker in overcoming the present confounding variable cannot be made.

As noted in the California MTUS’s [Introduction to the Chronic Pain Medical Treatment Guidelines](#), CP is a complex phenomenon inadequately explained by the “biomedical model” alone. Rather, in the biopsychosocial model, pain is “ultimately the result of the pathophysiology plus the psychological state, cultural background/belief system, and relationship/interactions with the environment (workplace, home, disability system, and health-care providers). Therefore, pain has become understood as a complex condition involving numerous areas of the brain. Multiple two-way communication pathways in the central nervous system (from the site of pain to the brain and back again) and emotional, cognitive, and environmental elements work together to form a complete, interconnected pain apparatus. Because it has numerous interacting and contributing causes and multiple effects, chronic pain resembles many other chronic diseases.”⁹

Fortunately, validated questionnaires can be used to identify those at increased risk for DR/CP as early as possible after DOI. In some early intervention programs, screening questionnaires are administered as early as two weeks post-DOI.

Bonica’s *Management of Pain* defines CP as “any pain that persists beyond the anticipated time of healing.”¹⁰ Similarly, delayed recovery is understood as existing when complaints and dysfunction persist beyond accepted timeframes outlined in standard disability guidelines.

In contrasting the biomedical and biopsychosocial models, it must be noted that the biopsychosocial model “recognizes the importance of illness behavior including cognitive and emotional responses to pain” as well as the necessary use of “self-management approaches in addition to medical management.”¹¹

Herein lies the critical distinction in the treatment approach taken between injured workers who recover in a timely fashion and those who do not.

Injured workers who do not recover in a timely way exhibit less emotional resilience in trying to overcome the consequences of bodily trauma and discomfort. They do not exhibit the coping skills of those who return to vocational and avocational activities in a timely way.

⁹ Gatchel RJ, Peng YB, Peters ML, Fuchs PN, Turk DC, The biopsychosocial approach to chronic pain: Scientific advances and future directions, *Psychological Bulletin* 2007;133(4):581-624; IOM (Institute of Medicine), *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (Washington, DC: National Academies Press. 2011).

¹⁰ Loeser JD, *Bonica's Management of Pain* (Philadelphia: Lippincott Williams & Wilkins, 2001).

¹¹ Hanson R, Gerber K., Table 2.1: Contrasting pain models in *Coping with Chronic Pain: A Guide to Patient Self-Management* (New York: Guilford Press, 1993), 30.

Psychosocial factors have proven better predictors of chronicity than clinical findings. Such variables/factors include, but are not limited to, a history of depression and anxiety, abuse, anxiety, depression, fear-based avoidance of activity, catastrophic thinking, fear of irreparability, external locus of control (LOC), perceived injustice, substance abuse disorder, patient/family dynamics and expectations, medical-legal claims management issues, and worksite/supervisor factors.

Cognitive behavioral therapy (CBT) is now effectively utilized in the management of many of these confounding variables through measures such as cognitive reframing, mindfulness, breathing techniques, pacing, and measured physical reactivation. For the engaged injured worker, such efforts improve resilience through improved coping skills. Once incorporated, such skills support a more rapid RTW, reduce needless overutilization (including medications), and minimize needless disability and suffering.

Recently, an emerging body of neuroplasticity literature supports the contention that that CBT techniques are associated with “winding down” pain through brain activation changes—specifically, decreased limbic (emotional) activation, decreased amygdala (fight/flight/freeze) activation, decreased anterior cingulate (rumination/addiction tendencies), and increased prefrontal cortex (thinking/distraction) activation.

These concepts are expanded on in the Introduction to the [Chronic Pain Guidelines](#) found in the CA MTUS. Other important references can also be found in it.

Medical Evidence Evaluation Advisory Committee (MEEAC)

To ensure that California’s injured workers have access to effective and appropriate treatment, the MTUS regulations created the Medical Evidence Evaluation Advisory Committee (MEEAC), a group of subject matter experts representing various medical fields that meets regularly to review the latest medical evidence.

The MEEAC provides recommendations to the AD on matters concerning the MTUS and advises the DWC medical director on potential revisions, updates, and supplements that will keep California’s treatment guidelines current.

The MEEAC’s recommendations are advisory in nature, are not mandatory, and do not constitute scientifically based evidence.

Chapter 9

Utilization Review (UR) and Independent Medical Review (IMR)

Key concepts:

- The Utilization Review Process
- Independent Medical Review
- Appeal of IMR Decisions

Introduction

Utilization review (UR) is the process used by employers or claims administrators to determine whether a requested treatment or other service is medically necessary. The goal of UR is to avoid unnecessary testing and treatments that may be harmful and are major cost drivers.

All employers or their workers' compensation claims administrators are required by law to have a UR program that assesses whether treatments or tests requested or provided to injured workers are appropriate and based on medical treatment guidelines (Labor Code § 4610; 8 CCR § 9792.6 et seq.). For further information on treatment guidelines, see Chapter 7. UR plans must be filed with the DWC AD, and UR must be conducted within strict timeframes.

Employers or workers' compensation claims administrators may conduct UR or contract with other organizations to perform UR.

Requesting Treatment

Treating physicians are expected to provide accurate reports of a patient's condition that provide the information necessary to support any requests made in the report for tests or treatment. It is not necessary for a treating physician to document the medical literature that supports a request, but the physician should provide enough information in a report to show that a diagnosis is credible or that one being considered is credible and that the diagnosis is consistent with a requested test or treatment and is supported by current medical scientific knowledge. As described previously (Chapter 7), requests for treatment should be submitted on the RFA form.

The UR Process: Who Reviews Requests?

Following UR, a request for treatment or testing may result in an approval, denial, or modification. An approval can be given by any member of a UR organization (insurance adjuster, claims representative, or nurse). If the request is not approved at the adjuster or claims representative level, it must be referred for UR by a physician. Only a physician may modify or deny a request for treatment or other service.

By law, a medical doctor (MD) or an osteopathic physician (DO) can, in light of the scope of practice for each, review *any* request. It is to be expected that the specialty of the treating physician will be matched, to the extent practicable and appropriate, with a reviewer of the same specialty or with a reviewer who is otherwise qualified to evaluate a request.

A chiropractic physician reviewer is more limited than a medical doctor or an osteopathic physician and can review tests or treatments requested by a chiropractor, or tests or treatments that fall

within the scope of chiropractic practice. Similarly, an acupuncturist reviewer is limited to evaluating requests, from any source, for acupuncture.

The UR Process: Gathering Relevant Information

In addition to approving the request, an adjuster, claims representative, or member of a UR organization can also do the following: (1) if a treatment request is clearly *inconsistent* with guidelines, ask the treating physician to consider modifying the request (in writing) so that it is consistent with the guidelines; or (2) if a report lacks information that is clearly relevant to supporting the request and is information that can reasonably be accessed by the treating physician, ask for that specific information. For example, a claims adjuster may request a clear description of physical findings to support a presumptive diagnosis of radiculopathy or an explanation of how a newly introduced diagnosis may be related to the original diagnosis for which a patient is under treatment.

A concurrent or prospective request requires an affirmative or negative decision no later than five working days after it is received by an adjuster, and the treating doctor must be informed by phone or fax within 24 hours of a decision (see below for further descriptions of concurrent and prospective requests). Any decision communicated by phone must be followed by written notice 24 hours after a decision for a concurrent request or two working days after a decision for a prospective request.

If more information is reasonably needed to make a decision and it was not provided with the original RFA, this information must be requested *within five business days* from the date that the written request was received. The UR decision must then be made *within 14 calendar days* from the date of first receipt of the RFA. If such additional information is not received within 14 days from the date of submission, the request will be denied, with the proviso that it will be reconsidered on receipt of the requested information. Note that such a request for additional information is considered a time extension and becomes a denial if it is not received within the required 14 days.

If an additional exam, service, or specialized consultation that is necessary to make a medical necessity determination is requested by the UR organization within five days of the RFA and is not received within 30 days of the RFA, the treatment request will be denied.

A written notice of denial or modification of a request must provide a clinical rationale and cite appropriate section of the MTUS or other medical treatment guidelines (by identifying the guideline and quoting or paraphrasing the relevant part of the guidelines). A written review must contain information that allows the treating doctor to contact a reviewer to discuss the decision and allows the injured employee to formally object to the decision (see section on IMR below). Review notices must contain specific language directed to the injured worker, explaining how to dispute a UR decision. Some insurers voluntarily provide an informal appeals process in which the treating doctor can offer evidence (in the form of clinical information or citation of medical literature that rebuts a guideline or by identifying an error in the notice of denial or modification) to argue against a UR decision.

Following are some relevant statements and rules concerning UR.¹²

Authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury.

Concurrent review means UR conducted during an inpatient stay. Medical care may not be discontinued until the requesting physician has been notified of the decision and a care plan has been

¹² 8 CCR §§ 9792.6-9792.11.

agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

The nonphysician provider of goods or services (e.g., a durable medical equipment provider) who has been identified in a request for authorization, and for whom contact information has been included, must be notified in writing of the decision modifying, delaying, or denying a request for authorization that must not include the rationale, criteria, or guidelines used for the decision.

Denial means a decision by a physician reviewer that the requested treatment or service is not authorized.

Emergency health-care services means health-care services for a medical condition manifested by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

Expedited review means UR conducted when the injured worker's condition is such that the injured worker faces 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, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

Prospective or concurrent decisions related to an expedited review must be made in a timely fashion appropriate to the injured worker's condition, **not to exceed 72 hours after** the receipt of the written information reasonably necessary to make the determination. The requesting physician must indicate the need for an expedited review upon submission of the request.

Modification means a decision by a physician reviewer that part of the requested treatment is not medically necessary while other parts are approved.

Prospective review means any UR conducted, except during an inpatient stay, prior to the delivery of the requested medical services.

Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker must be communicated to the requesting physician **within 24 hours of the decision**. Any decision to approve a request must be communicated to the requesting physician initially by telephone or fax. The communication by telephone must be followed by written notice to the requesting physician, the injured worker, and, if the injured worker is represented by counsel, to the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days for prospective review.

Decisions to modify or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker must be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone must 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 business days of the decision for prospective review. In addition, the nonphysician provider of goods or services identified in the request for authorization, and for whom contact information has been included, must be notified in writing of the decision modifying, delaying, or denying a request for authorization that must not include the rationale, criteria, or guidelines used for the decision.

Retrospective review means UR conducted after medical services have been provided and for which approval has not already been given.

When review is retrospective, decisions 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, **within 30 days** of receipt of the medical information that is reasonably necessary to make this determination. In addition, the nonphysician provider of goods or services identified in the request for authorization, and for whom contact information has been included, must be notified in writing of the decision modifying, delaying, or denying a request for authorization that does not include the rationale, criteria, or guidelines used for the decision.

Failure to obtain prior authorization for emergency health-care services is not an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health-care services. Note that the medical necessity of emergency health-care services may be assessed through retrospective review. Documentation for emergency health-care services must be made available to the claims administrator upon request.

Regardless of the type of review (concurrent, prospective, or retrospective), for all conditions or injuries not addressed by the MTUS, authorized treatment must be in accordance with other evidence-based medical treatment guidelines. The relevant portion of the criteria or guidelines used must be disclosed in written form to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, if used as the basis of a decision to modify or deny services. **Treatment may not be denied solely because the treatment is not addressed by the MTUS.**

Additional information about [utilization review](#) is available on the DWC website.

Independent Medical Review (IMR)

California's workers' compensation system uses a process called independent medical review (IMR) to resolve disputes about the medical treatment of injured employees (Labor Code §§ 4610.5-4610.6). As of July 1, 2013, disputes over medical treatment for all dates of injury are resolved by physicians through IMR, rather than through the court system, as was the case previous earlier. The costs of IMR are paid by employers, who are required by law to provide injured employees with all medical treatment that is reasonable and necessary to cure or relieve the effects of a work-related injury.

As described above, a request for medical treatment in the workers' compensation system must go through a UR process to confirm that it is medically necessary before it is approved. If UR denies, delays, or modifies a treating physician's request for medical treatment because the treatment is not medically necessary, the injured employee can ask for a review of that decision through IMR.

- Only the injured employee or his or her designee can request IMR. If the injured employee is represented, the employee's representative or attorney can request IMR.
- If the injured employee is unrepresented, he or she can designate a parent, guardian, conservator, relative, or other person as an agent to act on his or her behalf to request IMR.
- The physician whose request for authorization of medical treatment was delayed, denied, or modified may join with or assist the injured employee in seeking IMR.
- If the injured employee required emergency medical treatment because of an imminent and serious threat to his or her health, the provider of emergency medical treatment can submit an application for IMR.

IMR Application

Following a UR denial or modification of a request for treatment or service, the employer or claims administrator must send the injured worker a copy of the UR denial or modification **in addition to a partially completed application for IMR.**

To request IMR, the worker or a designee must sign and send in the following information within 30 days of receiving the UR denial or modification to the organization conducting IMR: (1) signed application for IMR that was sent by the employer or claims administrator; and (2) copy of the UR denial or modification.

If the request for IMR is made by a provider of **emergency medical treatment**, the deadline for filing the application for IMR is **within 30 days** of receipt of the UR decision concerning the provider's retrospective request for authorization of the emergency treatment.

To request an **expedited IMR**, the IMR application form must include the treating physician's certification that the employee faces an imminent and serious threat to his or her health. An expedited UR decision is eligible for an expedited IMR.

If, at the time of the UR decision, the claims administrator is also **disputing liability** for the treatment for any reason other than medical necessity (any assertion that a factual, medical, or legal basis exists that precludes liability), the **request for IMR is extended** to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

Review of Eligibility and Assignment

Following receipt of a complete IMR application (the signed IMR form and a copy of the UR denial), the AD makes a determination regarding the eligibility of the case for IMR. Reasons for ineligibility include failure to submit an IMR application within 30 days of the adverse UR determination, failure to sign the IMR application, and a dispute regarding liability. **After a case** is determined to be eligible for IMR, a notice is sent to the parties and medical records are requested from the claims administrator. Ineligible cases also receive notification.

Within 15 days of the medical records request for a regular application (and 24 hours for an expedited request), claims administrators must submit to the independent medical review organization (IMRO) all records and reports of the employee's medical treatment dating six months before the RFA. Other parties, including the injured worker, physicians, and attorneys, may submit medical records to be considered as part of IMR. Additional information can be requested from the parties when it is needed to complete the review. The party to whom the request for additional information is directed must send the information to the IMRO with concurrent service on all other parties within five business days of a regular review or within one calendar day of an expedited review. Cases are assigned to a physician reviewer (see below) after the medical records are received, and this starts the 30-day clock for issuance of a final determination.

IMR applications currently use a paper-based process; claims administrators have the option to submit medical records electronically through secure file transfer. This is likely to transition to increasingly electronic processes to be consistent with medical industry standards.

Terminations

An IMR can be terminated when any of the following are true:

- The treatments in dispute are authorized.

- The underlying workers' compensation case is settled by compromise and release.
- A material change in circumstance renders the IMR moot (e.g., there is a new treating physician with different course of treatment).
- The injured worker wishes to withdraw the request for IMR. Only the injured worker or his/her appointed representative can request a termination by withdrawal.

The written documentation must include a statement that the other party (defense/employer or applicant/worker) has been notified of the reason for the IMR termination.

IMR Decisions

The DWC is required to contract with one or more IMROs, to conduct IMR on its behalf. The IMROs are selected through a competitive bid process and then designated by the AD. IMROs contract with medical professionals, called **expert reviewers**, to perform IMR.

According to the law, expert reviewer must be licensed physicians in clinical practice knowledgeable in the treatment of the injured worker's condition, must meet rigorous qualification and conflict-of-interest standards, and may not serve simultaneously as an IMR expert reviewer and a QME. The law specifies that the identity of expert reviewers must be kept confidential by the IMRO. The IMRO assigns expert reviewers based on the specialty of the requesting physician and the content of the clinical issues involved in the medical treatment or services being disputed through IMR; reviewers are chosen so that the treatment or service is within their scope of practice.

Expert reviewers must make medical necessity decisions using evidence-based medicine. IMR decisions must state whether the requested service is medically necessary, include the employee's medical condition, relevant information from the medical record, and evidence to support the decision. The law specifies an order of medical evidence standards to be used when making medical necessity decisions as part of IMR, with the MTUS as the highest-ranking standard and preferred treatment guideline (Labor Code § 4610.5 (c)(2)).

The IMR decision must be provided in writing to all parties in layperson's terms within 30 days of receipt of the request for review or within 72 hours for an expedited request. [Individual IMR decisions](#) redacted of personally identifiable information are publicly available. These decisions serve as educational opportunities for treating and reviewing physicians, claims administrators, and others and can be used as an aid in making better evidence-based decisions when recommending and reviewing treatment and services.

Appeal of IMR Decision

IMR decisions may be appealed by filing a petition before a WCAB judge within 30 days of the mailing of the final determination. The final determination is considered a decision of the AD and is presumed correct, and the WCAB judge cannot make a finding of medical necessity contrary to the final determination. However, if the judge finds legitimate grounds for appeal, he or she can order that a repeat IMR decision be performed by a different IMRO or, if only one IMRO is available, a different medical reviewer. The following are grounds for appealing an IMR decision:

- The AD acted without or in excess of his/her powers.
- The final determination was procured by fraud.
- The medical reviewer was subject to a material conflict of interest.

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- The final 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 final determination was the result of a plainly erroneous mistake of fact.

Resources

[Further information](#) and [FAQs](#) about the IMR program are available on the DWC website.

Chapter 10

Evaluating Permanent Disability

Key concepts:

- Performing Disability Evaluations
- The Qualified Medical Evaluator (QME) Process
- Guidelines for Conducting a Disability Evaluation Using the AMA Guides
- The Almaraz-Guzman Standard

Physicians' Disability Evaluations

Most workers who are not able to return to work during a period of temporary or permanent disability must rely heavily on their workers' compensation payments. Physicians play a critical role in determining whether a worker will receive temporary or permanent disability payments, as well as how large the permanent disability payments will be. It is extremely important that both the medical-legal evaluator and treating physicians thoroughly understand the concepts and terms used in a disability evaluation.

Treating and evaluating physicians perform disability evaluations when the worker's injuries have become permanent and stationary. Final disability evaluation reports are prepared by physicians, who may be operating in the role of PTP, AME, or QME. It is important for physicians to be aware that many of the key stakeholders (e.g., claims administrators, attorneys, and injured workers) who will read their report are not medical professionals. Therefore, the language used in the report should be readily comprehensible to non-health professionals whenever possible.

The disability evaluation is used by the a rating specialist in the Disability Evaluation Unit (DEU) of the DWC, in conjunction with a rating schedule that correlates impairment with disability (Schedule for Rating Permanent Disabilities), to assign to the worker a **permanent disability rating**. The physician's disability evaluation report may also be used to determine eligibility for future medical treatment.

A final disability evaluation report, if not completed using the "Primary Treating Physician's Permanent and Stationary Report" form (the DWC PR-3 or PR-4), should be comprehensive and include the following components.

- Worker's name and demographics, such as date of birth and gender
- Claim number, Workers' Compensation insurer or third-party administrator and employer name, name of representative administering claim, date of injury
- History of presenting illness/injury
- Description of event(s) resulting in the injury or illness
- Summary of medical treatment, diagnostic studies, and clinical course up to the time of the appointment
- Discussion of work status and any restrictions or limitations
- Review of pertinent activities of daily living (ADLs)
- Pertinent medications
- Pertinent past medical and surgical history, such as previous injuries
- Pertinent social and occupational history
- Physical examination emphasizing the area(s) of injury or illness
- Diagnostic and laboratory testing results

- Medical records and medical-legal and consultative reports review
- Diagnostic impression(s)
- Statement whether the physician believes the worker is Permanent and Stationary (P&S) or has reached Maximum Medical Improvement (MMI)
- Recommendations for further treatment
- A description of subjective and objective factors of permanent disability and loss of pre-injury work capacity for cases rated under the 1997 schedule.
- A determination of the AMA Guides impairment rating/percent, with clear documentation of the process used to derive the rating
- Permanent work restrictions
- Apportionment: Provide percent of permanent disability apportioned, if any, and a clear rationale for the determination
- Determination that the worker can or cannot return to the usual and customary occupation with or without accommodation
- Time spent on face-to-face interaction
- Name and qualification of assistants involved in preparation of the report
- Statement that the physician did not violate Labor Code § 139.3 (self-referral)
- Mandatory declaration
- County of declaration
- Signature of physician.

How Disability Evaluations Are Obtained (QME Process)

The process for obtaining a physician's disability evaluation depends on the DOI and whether the worker has retained an attorney. A worker who is represented by an attorney is referred to as a represented worker and a worker with no attorney is referred to as an unrepresented worker.

The PTP performs a disability evaluation when that physician determines that the condition is permanent and stationary. The treating physician may either use a form developed by the DWC (PR-3 or PR-4) for the report or submit a narrative report containing all the required elements. The PTP's report may be used for settlement of the claim or serve as the trigger for the medical-legal process.

If either the worker or the employer wishes to contest the treating physician's evaluation, including the need for continuing medical care or the description of the permanent disability, arrangements will be made for a **comprehensive medical evaluation by an AME or a QME**, depending on whether the injured worker is represented or unrepresented (see Chapter 11 for a description of how a QME or AME is selected).

The PTP's report, the QME, or AME report are the only reports that a workers' compensation judge can consider in making a permanent disability award to an unrepresented worker.

How Disability Evaluations Are Used

If a case goes to trial before the WCAB, a judge may determine the factors of disability based on the medical evidence and request that the DEU issue a rating (called a **formal rating**) based on those factors. For represented workers, if the parties decide to pursue settlement negotiations, then those involved (applicant or defense attorney, claims administrator, or other worker or employer representatives) may use the physician's report and the DEU rating to calculate the worker's level of permanent disability. Either party may decide not to use the treating physician's report, and the

two parties may then agree to an AME or obtain a QME evaluation. Either party may also request a **consultative** rating on a QME report from the DEU. **In no case does the physician calculate the disability rating.**

If an unrepresented worker does not agree with the claims adjuster's rating of the treating physician's report, the worker may request a rating from the DEU. If either party disagrees with the treating physician's evaluation, a QME evaluation may be obtained using the process that is discussed in Chapter 11, Disputes in the System. All QME disability evaluations for unrepresented workers are rated (called a **summary rating**) by DEU raters. Should an unrepresented injured worker have two DEU ratings, one based on the treating physician's evaluation and one based on the QME's, the parties must either agree upon a single permanent disability rating or have the rating decided by a WCAB judge.

A worker's disability evaluation can have a major effect on the worker's life, because it will be a key factor in determining the amount of compensation the worker will receive. Because there is a limit on the number of evaluations a worker may have at the employer's expense, the PTP's evaluation may be the only evaluation for a particular worker. For this reason, it is critical that the report be comprehensive, accurate, and fair.

Guidelines for Conducting a Disability Evaluation Using the AMA Guides

Legislative reforms in 2003 ushered in a monumental shift in California Workers' Compensation with adoption of the *American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition* (hereafter, AMA Guides) in all permanent disability evaluations. The introduction of the AMA Guides dramatically changed the process for determining a permanent disability rating in California's workers' compensation. The physician's responsibility now centers on providing an **impairment rating** using the AMA Guides. This is this impairment rating along with an apportionment determination that comprises the responsibilities of physicians in the process of developing a permanent disability rating for the worker. The reform eliminated the physician's assessment of subjective and objective factors of disability, permanent work restrictions, and loss of pre-injury capacity as factors used in arriving at a permanent disability rating, although work restrictions are still needed for other purposes.

The goal of this section is to give an overview of how the AMA Guides are used in assessing permanent impairment. A comprehensive tutorial on the AMA Guides is beyond the scope of this chapter. Physicians in California should devote the necessary time to develop a working knowledge of the process and procedures detailed in the AMA Guides before embarking on permanent impairment ratings.

The AMA Guides, 5th edition,¹³ provides a standardized, objective approach to evaluating medical impairments. The AMA Guides present a methodology that seeks to enhance consistency in determining impairment ratings. The goal is for different physicians assessing the same worker to arrive at the same impairment rating. The approach taken in the fifth edition of the AMA Guides is "to update diagnostic criteria and evaluation process used in impairment assessment, incorporating available scientific evidence and prevailing medical opinion."

¹³ The sixth edition of the AMA Guide was published in 2008; however, the fifth edition is currently relied upon for use in medical-legal determinations in the California workers' compensation system.

Table 10-1. Activities of Daily Living

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

AMA Guides: Impairment

There are many definitions of impairment but no nationally accepted definition of the term. The AMA Guides define impairment as “a loss, loss of use, or derangement of any body part, organ system, or organ function.” Implicit in the definition is that there is a change from some normal or pre-existing state. This normative state can be based on the individual’s healthy pre-morbid condition or by assuming that their unaffected side is “normal.” Alternatively, population averages of healthy people can be used to make this determination. The AMA Guides support the use of both these approaches but encourage physicians to use accepted population values when applicable. A physician might choose to use an alternative normative state in assessing some individuals. For example, an endurance cyclist with permanent impairment after a partial lung resection might not be considered impaired relative to accepted population values, and would more appropriately be evaluated relative to a normative athletic population.

AMA Guides: Disability

Disability represents a limitation in an individual’s performance of tasks and is defined by the AMA Guides as “an alteration of an individual’s capacity to meet personal, social, or occupational demands or statutory or regulatory requirements because of an impairment.” This definition holds that an impaired individual may or may not have a disability. The distinction is important. Disability exists when an individual with impairment interacts with their environment and is incapable of performing one or more among an essentially infinite number of tasks. The AMA Guides assess the degree to which a given impairment decreases an individuals’ ability to perform common activities of daily living (ADL). The AMA Guides explicitly exclude consideration of work activities. The basis for this approach is that ADLs are common to most people and well understood, while work activities are diverse and complex. Table 10-1 lists the common ADLs referred to in the Guides.

This approach is significantly different from the one used previously in the California workers’ compensation system. Prior to the 2003 reforms, the worker’s loss of his/her ability to compete in

the open labor market was the basis for permanent disability evaluations performed by physicians. The AMA Guides' approach may be viewed as counterintuitive in the context of making a permanent disability determination for work-related injury and illness. It is important for physicians to recognize that the impairment rating derived through use of the AMA Guides is only one component used to develop a permanent disability rating for injured workers. The impairment rating is adjusted to account for the worker's diminished future earning capacity, occupation, and age at the time of injury to obtain the final permanent disability rating.

In the AMA Guides, impairment ratings for many conditions are given as a range of percentages or ratings (e.g., 15-18%). The physician decides the specific impairment rating—such as 3%, 4%, or 5%—that is appropriate for each individual. The ADLs in Table 10-1 are the basis on which the physician assesses how significantly a given impairment adversely affects these activities to arrive at the appropriate rating. So, for example, a person with little impact on ADLs would be given a rating at the lower end of the range while someone with more significant impact could be given a higher rating (18%).

AMA Guides: Organ System and Whole Body Approach to Impairment

The AMA Guides assign percentages or ratings to reflect the severity and limitations of the organ/body system impairment and resulting functional limitations. This is reflected in terms of whole person impairment (WPI) in most chapters of the AMA Guides. The musculoskeletal chapters are unique in providing regional impairment ratings that are subsequently converted into WPI using the Combined Values Chart (which is presented in the guides). This distinction arises from the unique characteristics of various organ/body systems. For example, spinal impairment will vary depending on whether it exists in the cervical, thoracic, or lumbar regions. It is also important for a physician to explain the rationale for using the particular method.

The range of WPI begins at 0%, at which there is no significant organ or body system functional loss, and the individual is not limited in his/her ability to perform ADLs. Conversely, 90-100% WPI denotes organ or body system impairment so severe that the individual is substantially or fully dependent on others for ADLs.

AMA Guides: Concept of Combined Values Chart

The **Combined Values Chart** is used to combine multiple impairment ratings into a summary value or WPI. Most of the time impairment ratings are combined using the combined values chart, with the following exceptions:

- Impairments of the joints of the thumb are added.
- Impairments of the ankle and subtalar joints are added.
- Range of motion impairments of the joints (spine and extremities) are added.

The chart has been crafted to ensure that the summary value does not exceed 100% of the whole person and that the sum of the multiple impairments is always less than or equal to the sum of individual impairment values. The chart is structured in such a way as to necessitate successive use of the chart when there are more than two distinct impairment values. The physician is instructed to combine distinct impairment values in the same region before combining the regional impairment value from another region. For example, multiple impairment values might be associated with the upper extremity region (e.g., neurological, abnormal motion, am-

putation). These separate impairment values should be combined prior to doing so with another regional impairment (e.g., respiratory system) to arrive at the WPI. In California, when combining more than two impairment values (after regional impairments have first been combined), it is necessary to combine the largest values and then combine that with the next largest until no values are left. Each value needs to be documented, not just the final WPI, as raters will often need impairment values for each body part in order to calculate the final disability rating.

AMA Guides: Pain

The AMA Guides' approach to pain may represent the most significant change in permanent disability rating in California's workers' compensation. Before the 2003 reform, pain was considered a subjective factor of disability for which the physician provided a qualitative assessment that could significantly increase the final permanent disability rating for a claim or even be the only basis for the rating. The AMA Guides and California regulations take a comparatively conservative approach to pain and allow the physician to add a maximum of 3% to the WPI rating when the pain is greater than that normally associated with the injury. The physician must decide whether the injured worker has more pain than normal and its effect on the ADLs. For instance, an impairment rating of 45% for a person who had back surgery would be expected to have a certain amount of pain. If the injured worker had an unusually high level of pain, the physician could add 1% to 3%, depending on how much disability the pain causes in ADLs.

AMA Guides: The Spine

The AMA Guides comprise 18 chapters, of which 15 deal with specific organ systems or anatomical areas. Each chapter is, to some extent, unique in the approach used to develop impairment ratings. The Spine (Chapter 15) is frequently used in assessment of impairment in work-related injury settings and can be used to illustrate some of the key concepts and approaches used to determine impairment ratings.

Two methods are available to assess spinal impairment, the Diagnosis-Related Estimate (DRE) and the Range of Motion (ROM) methods. The DRE method is used in cases of a distinct injury or where the cause is not easily determinable, but the impairment can be well characterized by the DRE method. Each of the three spinal regions (cervical, thoracic, and lumbar) used in the DRE method is divided into five categories. Category I is rated at 0% as only subjective complaints are evident, while each of the Categories II to V encompasses a range with adjustments of up to 3%. Determining which category is appropriate for the injury is based on either:

- symptoms, signs, and appropriate diagnostic test results based on clinical findings (AMA Guides, box 15-1, pp. 382-383); or
- fractures or dislocations with or without clinical symptoms

The ROM method is employed when one or more of the following circumstances exist: There is no injury.

- The cause is uncertain, and DRE does not apply.
- The condition cannot be easily categorized;

- Bilateral or multilevel radiculopathy is in the same spinal region;
- Alteration of motion segment integrity is at multiple levels (e.g., multilevel fusions), unless there is corticospinal tract involvement.
- Recurrent disc herniation or stenosis with radiculopathy is at the same or different level in the same spinal region.

The ROM method involves assessment of three elements. The first is determining the specific spine disorder impairment (e.g., fractures, disc, or other soft tissue lesion) using table 15-7 (p. 404). The second is calculating the range of motion impairment of the involved spinal region, and the third is evaluating motor and sensory impairment as described in chapter 15 (Spine) and in chapter 13 (Central and Peripheral Nervous System) in the AMA Guides. The WPI (see **AMA Guides: Organ System and Whole Body Approach to Impairment**) is obtained by combining the impairment ratings from all three elements using the combined values chart.

AMA Guides: Consistency

The maximum effort by an individual cannot be confirmed by using universally recognized indicators or tests. Therefore, physicians must use their clinical skills to assess objective findings in the course of an impairment evaluation. Measurements should be consistent and fall within 10% of one another.

The AMA Guides state: “If, in spite of any observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.” It makes sense for physicians to inform the worker being evaluated that the AMA Guides require consistency in measurements of range of motion, strength, and sensation and that inconsistency will reduce the final impairment rating.

AMA Guides: Assistive Devices

When an individual employs an assistive device, the physician should consider the following approaches, depending on case specifics. If the device can be removed or eliminated with relative ease, perform testing and evaluation without the device. Alternatively, the physician may choose to conduct an evaluation with and without the device and report both results. If the device is not easily removed, then perform the evaluation with the device in place.

AMA Guides: Adjustments for Treatment or Lack of Treatment

In some cases, treatment can result in apparently total remission of signs and symptoms— for example, in some cases of diabetes and hypothyroidism. In these cases, the physician may choose to increase the impairment rating by a small percentage (e.g., 1% to 3%).

By contrast, the treatment of some conditions can result in impairment in excess of the one that prompted the treatment (e.g., immunosuppressive or anticoagulant medications). In these cases, the physician should determine the impairment rating from the treatment and combine it with the primary organ system impairment.

AMA Guides: Documentation

Physician must thoroughly document the process and rationale used to arrive at the AMA Guides impairment rating(s) in their report. While the AMA Guides present significant structure for the disability evaluation process, they explicitly recognize that they cannot adequately address all potential impairment scenarios and rely on the physician to use reasonable medical judgment and common sense to arrive at the best impairment rating for a given individual. Consequently, physicians must clearly document both the rationale and the process by which they arrived at a given impairment rating. This includes a discussion of the approach taken and specific reference to all figures and tables with page numbers from the AMA Guides. Similarly, the physician must provide justification based on ADLs when selecting the low or high end of an impairment range.

Almaraz/Guzman Standard¹⁴

While most cases are rated based on the injury/illness and using the applicable chapter(s) from the AMA Guides, the series of Almaraz/Guzman decisions provides another way to rate a disability when the physician finds the case complex or extraordinary, such that the AMA Guides rating does not accurately reflect the worker's impairment.

A permanent disability rating can be rebutted by challenging one of its component parts, such as the WPI. In rebutting the WPI, a physician must stay within the "four corners" of the AMA Guides—which is to say the physician may use any chapter, table, or method in the AMA Guides to assess WPI.

Almaraz/Guzman does not allow a physician to arbitrarily choose a method in the Guides to achieve a desired result. Rather, his or her opinion must be supported by substantial evidence with facts and reasoning to support the rating. Again, there must be substantial medical evidence to support a departure from the typical path for determining a rating using the AMA Guides.

Almaraz/Guzman ratings that are provided should be clearly identified as such. An AMA Guides-compliant rating should also be provided to serve as a reference point for the discussion of why such rating does not accurately reflect the worker's impairment.

¹⁴ Milpitas Unified School District v. WCAB (Guzman) (2010) 187 Cal.App.4th 808, 75 CCC 837.

Chapter 11

Disputes in the System and the Role of the QME and AME

Key concepts:

- Medical-Legal Evaluations
- Qualified Medical Evaluators
- Agreed Medical Evaluators
- Represented and Unrepresented Employees
- How to Become a QME

Introduction

This chapter is written primarily for QMEs and AMEs, physicians who primarily conduct medical-legal evaluations within California's workers' compensation system.

Who Are Medical-Legal Evaluating Physicians?

Injuries that occurred on or after January 1, 1991, may be evaluated by QMEs. QMEs are appointed by the DWC Medical Unit and must pass a certifying exam. They are required to devote at least one-third of their practice time to providing direct medical treatment. An exception to this requirement is made for "exceptionally well qualified" physicians who are retired or hold teaching positions. QMEs are appointed for two-year terms.

An injured worker may choose to be represented by an attorney, and in such cases the law allows the employer and employee to agree on a physician to perform a medical evaluation. This AME need not be a QME. If a worker is not represented by an attorney, then an AME cannot be used. The AME need not have any special qualifications beyond being a licensed physician acceptable to both parties to a dispute. If the represented parties cannot agree on an AME, then either party may request a panel QME to resolve the medical dispute. The DWC does not regulate AMEs.

Finally, a PTP may also perform a medical-legal evaluation at the request of either party for the purpose of proving or disproving a contested claim that meets the regulatory requirements of 8 CCR § 9793 (h)(1)-(5). These instances are rare.

Overview

Medical-legal evaluations are an essential part of the resolution process when there is a dispute over a medical issue in a workers' compensation claim. The QME/AME report plays a major role in determining the injured worker's benefits including the worker's entitlement to:

- future medical care
- job modification, placement, or retraining
- partial income maintenance
- compensation for permanent disabilities.

As the name implies, medical-legal evaluations take medical information and put it into a legal framework. A medical-legal evaluator is retained to provide expert opinions regarding a medical issue, not to

provide medical treatment. This “testimony” is part of the written report and *must* include the physician’s findings *and* the reasons for all his or her opinions. Because the medical-legal evaluation is evidence in a legal dispute, it must address the issues that are in dispute.

The request for an evaluation should be accompanied by a referral letter from the applicant’s attorney or from the insurer, or, in rare cases, the injured worker may send a cover letter. This letter should describe the areas of dispute. If there is no referral letter, the QME will need to determine the relevant issues based on the available records and from discussion with the injured worker. The QME must address *all disputed* issues up to the time of the exam. The QME should always discuss and offer an opinion on all medical issues specifically requested in a referral letter or discussed with the injured worker during the exam. The QME may also address any issue that is believed to have a direct impact on treating the industrial injury. If, for example, the employer is disputing the extent to which a permanent lifting restriction was due to an industrial back injury, then the evaluator, if possible, must provide medical evidence on that issue. Extensive discussion of the worker’s previous history of hypertension may be relevant if treatment of the orthopedic condition cannot safely or effectively begin until the hypertension is under control.

When Are Medical-Legal Evaluations Required?

A medical-legal evaluation is performed only if the employer or employee disagrees with the treating physician’s evaluation. Reasons for obtaining a medical-legal evaluation include disputes over:

- whether the initial claim is compensable (i.e., whether the injury was caused by employment) (Labor Code § 4060)
- the existence and extent of permanent disability (Labor Code § 4061)
- the need for future medical treatment (Labor Code § 4061)
- the employee’s P&S status (Labor Code § 4062).

How Do Workers Get a QME Exam

Different processes for dispute resolution exist, depending on whether the injured worker is represented by an attorney. Represented employees are able to resolve disputes on a number of issues, described below, using an AME. A secondary process for selecting a QME can be used if no agreement is reached by the employee’s representative and the employer’s representative on the selection of an AME. By contrast, disputes involving unrepresented workers are always handled through a QME exam process.

A request for a QME must be submitted [electronically for represented workers](#) and [on paper for unrepresented workers](#). After a QME has been requested, the DWC Medical Unit generates a randomized list of three QMEs in the selected specialty and geographic area of the employee. The list of three QMEs is known as a “QME panel.” One QME from the list of three is then selected to perform the examination (see below for additional details).

Unrepresented Employees

If either the injured worker or the employer objects to a medical determination made by the treating physician, the employer must provide the injured worker with QME Form 105. If the unrepresent-

sented employee fails to request a QME panel within 10 days after the employer requests the injured worker to do so, the employer may then request a panel.

After the panel is issued, the unrepresented injured worker has 10 days to select a physician from the list. The injured worker must then schedule the appointment and notify the claims administrator. The selected QME notifies the parties that he/she has been selected to perform the medical-legal evaluation. The selected QME also should request on [QME Form 110 \(QME Appointment Notification Form\)](#) that the medical records be sent promptly. The claims administrator should then submit the records to the QME to review. An unrepresented worker who retains an attorney after QME evaluation is not entitled to have the employer pay for another comprehensive medical-legal evaluation.

Represented Employees

If an employee has an attorney and there is an issue of compensability, the evaluation is obtained using the following procedure.

If an attorney represents the employee prior to the QME evaluation, the employer and employee may try to agree on one AME to evaluate the issues in dispute. If no agreement is reached, the parties can request a QME panel. Within 10 days after the issuance of the panel, each party may each “strike,” or eliminate, one QME, and the remaining QME must then perform the QME examination. If one party fails to exercise the right to strike a name from the panel within 10 days, the other party may select any physician who remains on the panel to serve as the medical evaluator.

Permanent Disability and the Need for Future Medical Care

After the treating physician issues the P&S report (see Chapter 7), if the worker and the employer do not agree to a permanent disability rating based on the treating physician’s evaluation or the assessment of need for continuing medical care, then arrangements will be made for a comprehensive medical evaluation by an AME or a QME. This evaluation will address any and all medical issues that are in dispute at the time of the exam, not just issues related to permanent disability.

In the case of a represented employee with an objection to the PTP’s findings, the employer and the employee must wait at least the 10 day waiting period, plus 5 days for mailing of an objection before the DWC Medical Unit will be able to assign a QME panel. The parties may agree to an AME at any time. However, a QME panel may not be requested on any issue that the parties have agreed to submit or that has been submitted to an AME. Within 10 days of assignment of a QME panel, each party may strike one name from the panel. The remaining QME will serve as the medical evaluator.

All medical-legal reports regarding permanent disability must address the issue of apportionment, in addition to any other requested issues, or they will be considered incomplete.

Evaluations to Resolve Other Disputes

If one party objects to a medical determination made by the treating physician concerning the P&S status of the employee’s medical condition, the employee’s preclusion or likely preclusion to engage in his or her usual occupation, the existence of new and further disability, or other issues not covered by Labor Code §§ 4060 and 4061, the objecting party must notify the other party in writing of the objection within 30 days after receiving the report (or 20 days if the employee is represented). The employer must immediately provide an unrepresented worker with a form to request a QME in

an appropriate specialty. As described above, the worker chooses one of these QMEs and makes the appointment within 10 days after the issuance of the panel, or the employer may select the QME and make the appointment.

Resolving Disputes Over Medical-Legal Bills

- Make sure the exam performed is a valid medical-legal evaluation (see Labor Code § 4621 and 8 CCR § 9793). For example, for claims accepted by the employer, the report will be inadmissible if it is performed during the first 60 days after the notice of claim has been filed. An exam performed before then only invites a fee dispute.
- Do not perform unnecessary diagnostic tests or X-rays. If tests are necessary, offer a specific reason for them when requesting approval from the claims adjuster. If unusual or expensive testing is required, or if it is medically necessary to repeat tests performed in the recent past, notify the insurer in advance. Provide a sound medical justification for the requested testing.
- Follow the medical-legal fee schedule honestly. This should solve many problems before they start. The employer is required to pay all reasonable charges within 60 days. Under the fee schedule, this means that the employer should pay a minimum of \$500 for a standard uncomplicated medical-legal report (ML 102). Even if the payor disputes a charge above this level, the basic medical-legal fee must be paid within 60 days.
- If the dispute over the validity or the amount of payment cannot be resolved, the provider must file a lien and litigate the matter before the WCAB.

Resources

[Information on how to become a QME.](#)

Chapter 12

Writing the Medical-Legal Report

Key concepts:

- Required Elements of a Medical-Legal Report
- Timeliness
- Payment for the Report

Introduction

The importance of the medical-legal report in any workers' compensation case cannot be overemphasized. Reading this chapter alone will not provide all the information needed to write a good medical-legal report. In addition to reading and reflecting on the contents of this guide, additional review of selected references is recommended.

Required Elements of a Medical-Legal Report

The required elements of a medical-legal report are listed in Table 12-1. Although no particular format is required, it is beneficial for individual physicians to develop one that prompts them to include all the required information.

Medical-legal reports are prepared in the context of workers' compensation law, which has its own logic and definitions. It is essential for medical-legal reports to use the terminology and standards of the workers' compensation system. Other chapters and the glossary in this manual include explanations of many of the key terms.

The law does not require that the report be written in any particular style, but physicians should keep in mind that the main audience for the report is nonmedical. The worker, employer, claims administrators, disability raters, attorneys, and workers' compensation judges rely on the physician's opinion to make decisions that may drastically affect the applicant's life. Therefore, medical-legal report should be clear, concise, reasoned, internally consistent, and objective. In the words of a San Francisco workers' compensation judge:

CCR §10606 sets out what should be included in a medical report. However, it doesn't tell you why that is needed. . . . It's because nonmedical personnel, such as claims examiners and workers' compensation judges need all that information to properly do their job. A workers' compensation judge's determination based on a medical report that is just a string of unsubstantiated conclusions is no better than judicial dart-throwing. . . .

For the medical report to be usable it should clearly explain why the medical conclusions are reached in a way that someone who is not a medical expert can understand. Then, the claims examiner, or ultimately a workers' compensation judge, can use that information in making his or her determination.

A disability rater concurs on the need for internal consistency: "I can handle it when the report's findings are inconsistent as long as the physician tells me why. If the work restrictions don't logically match what you've said in your findings, you need to explain why ... to give your reasoning. Otherwise, the rater has no possible idea of what may be going on with that worker. Without the explanation the rater is basically left to guess, which may well not be to the benefit of the worker."

Table 12-1. Required Elements of a Medical-Legal Report

- Summary form (for QME and AME)
- DEU Form 100 (unrepresented QME only; report must contain comments about the form)
- DEU Form 101
- Date and location of the exam
- Statement that the physician actually performed the examination
- Time spent face to face with the injured worker
- Listing of material reviewed or relied upon to prepare the report
- History of the present injury or illness
- Present complaints
- Medical history including injuries, conditions and residuals
- Findings of the examination, including laboratory or diagnostic test results
- Diagnosis
- Factors of disability: subjective, objective, work restrictions, estimate of loss of pre-injury capacity (used when the old schedule applies; for date of injury on or after January 1, 2005, impairment rating based upon AMA Guide)
- Opinion on whether permanent and stationary
- Cause of the disability (work caused/work contributed)
- Treatment currently needed
- Future medical treatment where reasonably, medically probable
- Impairment rating based upon AMA Guide
- Apportionment of disability, if any
- Reasons for opinions
- Disclosure of name and qualifications of anyone who assisted in report
- Mandatory declaration in its entirety
- Statement concerning that physician did not violate LC 139.3
- Original signature of physician with the date signed and county noted

The physician who signs the report must be the only person who examines the injured employee or who participates in the nonclerical preparation of the report. Nurses are permitted to perform functions

that are routinely performed by a nurse, such as taking blood pressure. The DWC requires that examinations by QMEs for unrepresented injured workers be conducted *only* at the office location noted on the [Selected Qualified Medical Evaluator Panel](#) Form and at no other location.

The following sections describe the types of information that should be included in the report.

Identifying Information

The heading of the report should provide the information necessary to identify the report, including:

- Date of the report;
- Name of the applicant;

Table 12-2. Face-to-Face Time Requirements

All QME evaluations are required to include the amount of time spent face to face with the injured worker in their report (8 CCR §§ 49-49.9).

<u>Examination Type</u>	<u>Minimum Minutes Required</u>
Neuromusculoskeletal	20
Cardiovascular	30
Pulmonary	30
Psychiatric	60
All others	30

Face-to-face time does not include time spent in the parking lot, waiting room, or time spent filling out pre-evaluation history forms.

- Date of injury;
- Claim number;
- WCAB adjudication case number (ADJ number), when possible.

Opening Statement

This section should provide information on the context of the report and the performance of the examination. Evaluators are required to provide the date, place, and duration of the exam. The “face-to-face time” spent by the physician with the injured worker has specific minimum time requirements (see Table 12-2). This time includes the time in which the evaluator takes the history, performs the physical exam, or discusses the worker’s medical condition with the worker. Face-to-face time does not include time spent in performance of diagnostic or laboratory tests (e.g., blood tests or X-rays) or time spent on reviewing records or writing reports.

Sources of Information

This section should contain a list of all the medical records that were reviewed in preparation of this report. Any nonmedical information, and its source, received from either party and reviewed in preparing the report or in formulating an opinion should be recorded. The names of anyone other than the patient who was interviewed or with whom the case was discussed should be listed.

History of the Present Injury or Illness

The purpose of the history section, according to retired Workers’ Compensation Judge Pamela Foust, is to provide:

sufficient information regarding the nature of the injury and the patient’s relevant physical or emotional condition before, after, and during the alleged injurious exposure to understand what the applicant is claiming happened to him and why. . . . A skilled attorney will know what questions to ask to present his client’s story in the best light at trial. Likewise, a skilled foren-

sic doctor who believes there is merit to an applicant's case from a medical standpoint will be able to elicit information and report the facts in such a manner that the reader will understand the basis for applicant's claim.¹⁵

The report must include a comprehensive and factual account of the industrial exposure, the applicant's complaints, and the treatment the applicant has received. The nature of the claim will determine the extent of the history. Injuries resulting from cumulative trauma or occupational illnesses (as opposed to a physical injury) will require a detailed explanation of the applicant's job duties, the conditions of the injurious exposures, including the approximate time spent on the tasks in question, and the temporal relationship between the exposure and the symptoms. The discussion should include any occupational exposures, including those from previous jobs that may have contributed to the condition. A description of the onset or progression of symptoms experienced by the injured worker, including the timeframe in which these occurred, should be provided.

The history for a specific injury should describe the activity that immediately preceded the accident and how the accident occurred. Wherever possible, relevant details, such as the approximate weights of objects, the worker's position while performing the task that resulted in injury, the height of a fall, or the names of chemicals to which the worker was exposed, should be provided. If the worker provides Safety Data Sheets (SDSs) (formerly known as Material Safety Data Sheets, or MSDSs) or other exposure documentation, these should be attached to the report. Any information about conduct that might indicate that the employer has been seriously or willfully negligent should be included.

The report should describe what happened after the injury—for example, whether the applicant was transported by ambulance to a hospital or continued working that day and sought treatment later. This section should also summarize the current and past treatment. If there is more than one injury, the report should clearly describe each injury and the subsequent treatment, or changes in treatment, if treatment was ongoing at the time of the second injury.

In some cases, the physician may have an assistant make an initial outline of the patient's history or take excerpts from prior medical records, to prepare the physician for personally taking a thorough history and summarizing the records. However, the physician must review the excerpts and outline with the patient and make any necessary additional inquiries. The physician can assign other trained and qualified individuals to perform diagnostic tests. The name, qualifications, and role of everyone involved in making outlines or excerpts, in performing diagnostic tests, or in drafting the report must be disclosed.

Present Complaints

This section should explain in detail the patient's current complaints and relate the frequency, duration, and intensity of the complaints to specific activities and note temporal patterns, such as stiffness in the morning or pain that increases throughout the day. For injuries that fall under the [old permanent disability rating schedule](#), pain that interferes with activity is a "ratable" disability in workers' compensation, so it is important for the report to give a clear explanation of the extent of any limitations.

Before the examination, the physician should have received copies of all materials relevant to the evaluation from the employer or insurance carrier. For disability evaluations, the unrepresented

¹⁵ Honorable Pamela Foust, Workers' Compensation Judge, "Handling Medical-Legal Issues: An Analysis and Proposal," Conference of California Workers' Compensation Judges, Los Angeles (1992), p. 32.

Box 12-1. Importance of a Quality Report

The most frequent types of problems we have with medical-legal reports are untimeliness, failure to use appropriate terminology, incomplete medical evaluations, and internal inconsistencies in the reports.

The physician has to realize that we don't have the patient standing in front of us. All we have is their report. Since we have to do our best to rate all reports, the physician community has to produce reports that (1) reflect reality and (2) are ratable. There's just no other way to put it.

—DEU Disability Evaluator

worker should also receive and fill out an Employee's Permanent Disability Questionnaire ([DEU Form 100](#)). The QME should review this form and discuss any conflicting or missing information with the worker. If the worker does not have this form, the QME should have the worker fill one out at the time of the appointment. The QME should also receive a Request for Summary Rating Determination ([DEU Form 101](#)) from the party requesting the disability evaluation. The request form contains the address of the DEU office to which the completed medical evaluation, together with DEU Forms 100 and 101, must be sent. The DEU will not complete a disability rating unless the two completed forms are submitted with the medical evaluation report.

The evaluating physician should accurately repeat the worker's version of physical limitations and distinguish between activities that the applicant avoids and activities that the applicant finds impossible to do. Overstating the applicant's claimed limitations may cause the applicant to be discredited, while understating those limitations may limit access to treatment or other benefits.

Other Medical Information

These sections should summarize important medical events or conditions that may have bearing on the applicant's injury, the social history, review of systems, and any other relevant medical information. The applicant should be questioned about any pre-existing injuries or conditions in the affected part of the body. These sections should also report other conditions or disabilities that may affect the degree of disability this injury has caused. For example, an applicant who had previously lost the use of his right leg will suffer greater disability from an injury to his left hip than someone who was previously unimpaired. Workers' compensation recognizes certain combinations of impairments as total disabilities, even though either impairment by itself is not considered totally disabling. Any relevant occupational history information should be described.

When these sections are prepared, information from medical records provided for this examination should be considered. Extensive quotations from the records are not needed, but important points should be noted, especially those about any pre-existing conditions or treatments. Any discrepancies between the records and information supplied by the applicant should be discussed with the applicant and noted in the report. Occasionally, the discussion with the patient can reveal the existence of other medical records that should be reviewed. The regulations governing QME and AME examinations limit information provided to the evaluating physician and limit communications with any party other than the patient. Evaluating physicians are not allowed to communicate with any party to the action other than those involved in the evaluation exam, except in writing, and any written communication must be served on the

opposing party within 20 days (except for requests for releasing medical records). See Chapter 15 for more information on ex parte communication.

Findings of the Examination

This section should include both findings from the clinical examination and the results of diagnostic tests that are administered. Findings should be presented simply and directly.

The section should describe the purpose of clinical tests, rather than referring to the tests only by name. It is helpful to keep in mind that the main function of this report is to enable people who are not physicians to evaluate the case in the workers' compensation system.

If any diagnostic tests, such as X-rays or electromyographies (EMGs), have been performed, they the findings should be summarize in this section.

Diagnosis

This section should give a specific diagnosis for each and every condition being evaluated. If a specific diagnosis cannot be made, an impression or differential diagnosis should be indicated.

Cause of the Injury

This section addresses the relationship between the conditions found on examination and the injury or occupational exposure. In some situations, this section can be quite brief. For example, "the employee's fracture resulted from the fall he sustained on January 23, 2014." More detailed discussion is required in cumulative trauma cases, occupational illnesses, stress claims, or in cases where additional body parts or systems have become affected since the original injury. An explanation should be provided about how different exposures or tasks contributed to the condition. An explanation should be provided about how or why any symptoms developed that are secondary to the original injury. For example, a statement may include that the applicant developed low back pain due to the altered gait that was caused by his knee injury. Statements on this section should be as direct and definite as possible. Terms such as "possibly" or "maybe" should be avoided because they have no definition in the system.

It is not necessary for work activities to be the entire cause of the injury. Work can be a contributing or aggravating cause. If there is permanent disability, and the injury is described as an aggravation to an existing condition, that issue should be addressed in the apportionment section of the report. Psychiatric injuries are held to a different standard of causation.

All work exposures should be considered in determining causation in cumulative trauma or occupational illness cases. However, the last year that the employee had the hazardous exposure should be identified, because the law limits liability to the applicant's employers during that year (Labor Code § 5500.5).

If conflicting accounts of how the injury happened affect the evaluator's opinion regarding causation, then the opinion should be expressed conditionally in each of the possible scenarios. It is not the physician's job to determine which history is correct. However, if the medical evaluation corroborates or is not compatible with one of the histories that has been provided, the physician should note that in the report.

California law (Labor Code § 3212) contains rebuttable presumptions regarding causation for certain injuries in certain occupations (see Chapter 3). In evaluating those injuries, opinions in support of causation or opinions and evidence to rebut the presumption should be provided.

Box 12-2. The *Rushing* Decision Defines Forms of Treatment

“Section 9785 uses the terms *continuing treatment* and *further treatment*; not future treatment. The terms are not interchangeable. Continuing means constant, needing no renewal: lasting, enduring (*Webster’s Third New Internat. Dict.* (16th ed. 1971) p. 493). “Further” indicates “going or extending beyond what exists” (*id.* at .924). The terms “continuing” and “further” denote treatment protocol that is ongoing, uninterrupted and unceasing. By contrast, future is “existing or occurring at a later time” (*Id.* at p. 926). Hence, “future” medical care suggests medical attention which would be required at a later date.”

—Tenet/Centinel Hospital Medical Center v. WCAB (*Rushing*) 80 Cal. App. 4th 1041; 65 C.C.C. 477

Psychiatric evaluations have one additional requirement. These reports must contain a determination whether work factors were the predominant cause (at least 51%) of the injury.

Opinion on Permanent and Stationary Status

This section should state whether the patient’s condition has been determined to be permanent and stationary, along with the reasons for this determination.

Factors of Disability

(Note: This is used when the old Permanent disability rating schedule applies. If the DOI is on or after January 1, 2005, impairment rating based upon AMA Guide, see Chapter 10.)

This section should describe any permanent disability that will result, or has resulted from, the injury. It is very important to be thorough and specific in this section, because it will be a basis for the DEU rating. For each body part or system being evaluated, the physician should provide an opinion on:

- subjective factors
- objective factors
- work restrictions
- estimate of limitations or loss of pre-injury capacity.

Opinions in this section should relate to the information provided in the findings section of the report. Based on the patient’s subjective complaints and on the examination, the physician should describe any subjective disability. For example, limitations due to pain should be identified by a description of the activity that produces the disability, the duration of the disability, the activities that are precluded by the disability, those that can be performed with the disability, and the means necessary for relief.

If the physical examination revealed a restricted range of motion, this section should then describe the resulting range of motion. Describe any loss of a body part, disfigurement, atrophy, or measurable loss of function, including range of motion or strength, as well as any device or prosthesis that should be used.

This section should also describe any work restrictions that should be placed on the worker, regardless of whether they are specifically relevant to the applicant’s current job. Work restrictions

Box 12-3. Calculating Future Medical Costs

A 45-year-old worker has an episode of back pain resulting from a disc problem. It is not a surgical problem at this time. The physician writes the following in the medical-legal report under “Need for Future Medical Care”:

I estimate that this patient will need the following care:

- Two to three office visits per year to evaluate progression of the back problem;
- Physical therapy for periodic recurrence of the problem (approximately six sessions per year);
- Four tablets per day of anti-inflammatory medication, ongoing;
- S1 laminectomy and discectomy, to be determined by treating and consulting physicians.

can be actual or preventive (prophylactic). Actual work restrictions are those that the employee cannot perform, either because the employee is physically prevented from doing so, such as being unable to bear weight on an injured ankle, or because the activity causes severe pain. Preventive work restrictions are appropriate to:

- avoid or prevent undue pain
- avoid causing an increase in symptoms that would lead to a period of temporary disability
- avoid causing increased permanent disability
- prevent exacerbations that would increase the need for medical care.

After the actual work restrictions have been clearly defined, the physician should also *separately* describe the worker’s loss of pre-injury capacity. A description should be included of what the worker could do before the injury, compared to after the injury. Based on that description, an estimate of the percentage of loss of capacity should be provided.

Apportionment of Disability

This section should describe the degree to which any permanent disability is due to pre-existing conditions or underlying disease. Apportionment is a legal concept and applies only to permanent disability. It is never applied to medical treatment, temporary disability, or death benefits. Apportionment can be based only on causation of permanent disability. It is not correct to base apportionment on personal risk factors, asymptomatic disease, or pathology. The physician is being asked to determine the portion of the disability that would have existed without the current injury.

Apportionment should be addressed if there are applicable pre-existing conditions or underlying disease, or if it is indicated in the causation section that the injury is an aggravation of an existing condition or previous injury. The evaluator should explain the portions of the findings that affect their opinion on apportionment. The existence of underlying disease or pre-existing injury does not automatically justify apportionment to those factors, but the issue should be addressed.

Medical Treatment Indicated

Labor Code § 4600 provides that an injured worker is entitled to treatment reasonably required to cure or relieve the effects of an injury. Disputes regarding current medical treatment or involving retrospective review of treatment provided must be resolved through IMR and may not be addressed by a QME or AME. However, issues involving the need for future medical treatment may be addressed in medical-legal reports.

Providing for Future Medical Treatment

A worker may still require further medical treatment even after the worker's condition is permanent and stationary, and workers may receive awards that include future medical care if the treatment is needed:

- to maintain the worker's optimum condition
- to relieve or cure the effects of the injury
- to relieve the effects of exacerbations or recurrences that are reasonably expected from the worker's condition.

Treating and evaluating physicians should carefully consider and calculate the need for future medical treatment and include as much detail on this as possible in their reports, without including finite numbers and dollar amounts. When medically appropriate, future medical treatment must be awarded by the WCAB. The physician is in the best position to estimate what the needs might be (see Box 12-3). This estimate should include check-ups, anti-inflammatory or pain medication, splints, future surgery, future hospitalization, and any other necessary medical care. The WCAB will not be bound by estimates of an injured worker's medical needs in a P&S report. The WCAB will look at the reports of the treating physician, and possibly a QME, at the time medical care is requested by the injured worker.

Reasons for the Opinion

For each opinion, provide a clear description of why the opinion was reached. The evaluator should also provide explanations for any unusual findings. This should be done throughout the report, in the appropriate sections. Avoid meaningless summaries such as "My opinion is based upon the patient's history, the examination findings, and the available medical records." A medical-legal report that does not contain the reasoning behind the medical opinions reached is worthless in the workers' compensation system.

Disclosure of Other Individuals Involved

The report must disclose the name, qualifications, and roles of other individuals who participated in the evaluation by performing such tasks as:

- taking and outlining the medical history
- reviewing and summarizing medical records
- administering diagnostic studies
- drafting or editing any part of the report.

Table 12-3. Excerpts from Inadequate Reports

Many medical-legal reports do not provide the information necessary for raters or judges to make decisions about worker's cases. Following are several excerpts of inadequate medical-legal reports, with accompanying comments on how the report should be changed.

<p>WORK PRECLUSIONS: I would preclude any heavy lifting or prolonged repetitive activities with her right upper extremity and any gripping with her right hand.</p>	<p>Comment: These work restrictions are too vague. Work restrictions should be more specific to the actual precluded tasks and limits (i.e., keyboarding), % loss of pre-injury capacity for lifting, or gripping activities.</p>
<p>DEGREE OF DISABILITY: The left foot complaints preclude him from prolonged weight-bearing activities and limit him to semi-sedentary work.</p> <p>However, this does not affect such things as stooping or bending or lifting capability, and the raters should take this into account when considering his overall working capacity. The left knee and low back complaints appear to represent minimal hindrance to his activity and would not add significantly to his disability level.</p>	<p>Comment: These work restrictions are too vague and internally inconsistent. If a patient is precluded from weight-bearing activities, this would likely affect lifting capability.</p>
<p>FUTURE MEDICAL TREATMENT: As was stated previously, based on present findings on examination, there is no clinical indication to warrant any further diagnostic studies or active treatment, other than on a simple supportive and symptomatic basis. It is felt, however, that, based on symptoms over this period of time of some six years, and with the pathology as noted from the previous arthroscopic procedures performed, medical care should be afforded to him in the future with any settlement in the event that his symptoms do progress or become intolerable where he would need a more active treatment program, including the possibility of further surgery.</p>	<p>Comment: Future medical care needs to be much more specific. What kind of treatment? How frequent? What kind of surgery?</p>
<p>DISCUSSION: The patient sustained a serious injury on January 17, 1992. It is very likely that he has had subclinical psoriatic arthritis for a long time prior to the injury. It is very possible for the psoriatic arthritis to precipitate as a result of trauma. In consideration of the patient's overall medical condition, it is reasonable to assume that the patient has reached the permanent and stationery status. The objective factors and the patient's disability rating are very minimal, perhaps less than 5% of the right upper extremity. The subjective complaint plays a significant role in the range of about 10% of the right upper extremity. However, there is a contributing factor, which is his psoriatic arthritis and history of his gout. I would estimate that 20% of his disability is contributed by the underlying medical problem, and 80% by the injury itself.</p>	<p>Comment: It is not correct to apportion to an underlying condition unless the physician can demonstrate that the symptoms would have occurred regardless of the industrial injury. The physician has not done so in this report.</p>

Table 12-4. The End Result of Inadequate Reports: Rejection and Delay

EVALUATION OF QME REPORT	Comment:
Physician Name: Dr. Smith	Dr. Smith indicates decreased range of motion of wrist, but does not provide measurements. Says there are symptoms on use, but doesn't describe what these symptoms are. Report is unratable, necessitating writing to the QME.
This QME report could not be used for disability rating because:	
Report failed to provide adequate information on factors of disability.	
Report failed to address necessary legal issues.	
Report was internally inconsistent.	
Other:	

The name of the transcriptionist is not required. Violation of this provision can result in suspension or termination as a QME (Labor Code §§ 139.3, 4628).

Mandatory Declaration

Since all reports, whether comprehensive medical-legal, supplemental, or follow-up reports, are submitted to the WCAB and may be used in evidence, the following declaration in its entirety must be included in every medical-legal report:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Signature

The report must be signed by the physician who prepared the report, under penalty of perjury (Labor Code § 4628(j)). In order to sign the report, the signer must have examined the applicant, taken the applicant's history or reviewed with the applicant an outline of the history, reviewed the medical records, and composed and drafted the conclusions of the report. Include the date and county where the declaration was signed.

Disclosure of Any Significant Beneficial Interest

The report must disclose any proprietary interest or co-ownership the physician has in any laboratory, pharmacy, clinic, or health-care facility used in the evaluation. QMEs and AMEs are generally prohibited from most self-referrals, with some exceptions (Labor Code § 139.31). The report must contain the statement that the evaluator has not violated Labor Code § 139.3, that there have been no illegal referral(s). Failure to include this statement, however, is not necessarily fatal and may be remedied by a later amendment (*Leyba v. LSI Logic Corp.* (1995) 23 CWCR 230). For more infor-

mation on prohibited self-referrals, see Chapter 6. Violation of this section can result in suspension or termination as a QME.

Required Forms

Several forms must be attached to the medical-legal report. For QME and AME reports, the reporting physician must include a copy of the summary form (QME Form 111). If the injured worker is unrepresented, DEU Form 100 and DWC AD 101 must also be included, and the report must contain comments about DEU Form 100. If the injured worker is represented, only DEU Form 101 must be included, but no comment about it is required nor is the Summary Form required.

Timeliness

The timely submission of reports is mandated by law. For injuries between January 1, 1991, and December 31, 1993, the report must be prepared and submitted within 45 days after the evaluator has seen the employee or otherwise commenced the evaluation procedure. For injuries on or after January 1, 1994, the report must be submitted within 30 days. Forty-five-day extensions (for injuries between January 1, 1991, and December 31, 1993) and 30-day extensions (for injuries on or after January 1, 1994) will be approved only when the evaluator has not received test results or a consulting physician's evaluation in time to meet the initial deadline. In this instance, the evaluator must notify the employee and the employer/insurer/claims administrator no later than five days before the end of the initial 30- or 45-day period of the request for the extension. A request for an extension must be sent to the Executive Medical Director at the DWC Medical Unit.

Payment for the Report

The employer must pay for medical-legal expenses within 60 days after receiving the written billing and report, unless the employer contests the reasonableness or necessity for incurring the expense. When the payment is not made as required, the "unreasonably unpaid" amount can be increased by 10%. The employer is also liable for 7% interest per annum retroactive to the date the bill was received (Labor Code § 4622). Medical-legal reports must be billed in accordance with the medical-legal fee schedule. The evaluator can reduce delays and facilitate speedy payment by including supporting information in the report as to how the billed levels were achieved (i.e., hours present or elements included).

Chapter 13

Payment of Physicians and the Official Medical Fee Schedule (OMFS), RBRVS, E-Billing, and IBR

Key concepts:

- Provider Billing and Payment
 - Official Medical Fee Schedule (OMFS)
 - The Physician Fee Schedule
 - Standardized Paper Billing and Electronic Billing
- Resolving Billing Disputes
 - Request for Second Review
 - Independent Bill Review (IBR)

Provider Billing and Payment

Laws and regulations for provider billing and payment in the California workers' compensation system have changed extensively over the past several years, including new and revised fee schedules and the adoption of standardized medical billing rules. This chapter provides an overview of fee schedules, including the Physician Fee Schedule, paper and electronic billing, and the independent bill review process. Refer to the DWC Official Medical Fee Schedule website or specific and current information, as fee schedules and rules are very detailed and updated regularly.

Official Medical Fee Schedule

Medical treatment in the California workers' compensation system is paid by the workers' compensation insurance claims administrator (the insurer, self-insured employer, or third-party administrator) using the DWC Official Medical Fee Schedule (OMFS). The fee schedule is updated through rulemaking and through AD Update Orders issued pursuant to Labor Code § 5307.1(g). It is essential to consult the Physician Fee Schedule website to obtain the most recent updates to the fee schedule.

The OMFS establishes the maximum allowable fee for services unless the payor and provider contract for a different payment amount. The OMFS for physician services applies to all services performed by physicians and other nonphysician practitioners, but other fee schedules may also apply.

Fee schedules include but are not limited to the following:

- ambulance
- copy services
- durable medical equipment, prosthetics, orthotics, and supplies
- hospital outpatient departments and ambulatory surgical centers
- inpatient hospital
- interpreter
- medical legal fee schedule
- pathology and clinical laboratory

- pharmaceuticals
- physician services

All the regulations, documents, and data files that constitute the fee schedule are available for downloading at the [DWC website](#), the Medicare website, or the Medi-Cal website, with the exception of the *Current Procedural Terminology*® (CPT), which must be purchased from the American Medical Association (AMA).

The Physician Fee Schedule

The legislative reforms of 2012 required the physician fee schedule to be based on the resource-based relative value scale (RBRVS) fee schedule, which is maintained by the Centers for Medicare and Medicaid Services (CMS). Effective in 2014, a new transition factor will take effect each year during the transition period between the old fee schedule and the RBRVS-based fee schedule for services rendered beginning on or after January 1, 2014, with full implementation in 2017. Multiple conversion factors (see below) from the old workers' compensation payment system will transition to a single conversion factor to align with Medicare in 2017. The conversion factor beginning in 2017 is calculated at 120% of Medicare (using the conversion factor in effect in July 2012 as the base year), updated for inflation. This excludes anesthesia services, which have their own conversion factor.

The RBRVS fee schedule has three basic elements:

- **relative value units (RVUs)** for each medical service based on the resources associated with the physician's work (the time and skill required for the procedure), practice expenses (the staff time and costs of maintaining an office), and malpractice expenses. For some services, the RVUs for practice expenses vary based on whether the service is performed in the physician's office or at a facility.
- **a conversion factor (CF)** that converts the RVUs into a payment amount for the service. Medicare uses a single CF for all services except anesthesia. Anesthesia is priced under a different scale and has a separate CF. Workers' compensation will transition to one CF for anesthesia, and one CF for "all other services" beginning in 2017.
- **a geographic adjustment factor (GAF)** that adjusts for geographic differences in the costs of maintaining a physician practice. Medicare uses adjustment factors for nine geographic localities in California, but for workers' compensation the regulations adopt statewide average GAFs. For services other than anesthesia, the RBRVS-based regulation uses statewide average geographic adjustment factors for each RVU component, instead of Medicare's nine locality adjustments. For anesthesia, there is one statewide GAF for all anesthesia procedures because anesthesia "base units" are not broken down into work, practice expense, and malpractice components.

Every year, CMS updates the procedure codes, inflation factor, and Medicare RVUs; the DWC has 60 days to enact those annual changes. The DWC also adopts relevant Medicare midyear updates. A wide variety of providers is subject to the physician fee schedule. These include both physicians and nonphysicians (see Table 13.1).

Maximum fees for the services of a physician or nonphysician practitioner are governed by the Physician Fee Schedule, regardless of specialty, for services performed within his or her scope of practice or license as defined by California law. Evaluation and management codes are to be used

Table 13.1. Providers Subject to the Physician Fee Schedule (Labor Code § 3209.3)

Physicians	Nonphysician Practitioners
MDs and DOs	Nurse practitioners, clinical nurse specialists
Psychologists	Physician assistants
Chiropractors	Physical therapists
Acupuncturists	Speech therapists
Dentists	Occupational therapists
Optometrists	Clinical social workers, marriage and family therapists
Podiatrists	Certified registered nurse anesthetists, anesthesiology assistants

only by physicians (as defined by Labor Code §3209.3), as well as physician assistants and nurse practitioners who are acting within the scope of their practice and are under the direction of a supervising physician. Osteopathic Manipulation Codes are to be used only by licensed doctors of osteopathy and medical doctors.

Physicians and nonphysician practitioners must use other applicable parts of the OMFS to determine maximum fees for services or goods not covered by the Physician Fee Schedule, such as dispensed pharmaceuticals, pathology and clinical laboratory and durable medical equipment, prosthetics, orthotics, and supplies with the following exceptions: (1) where such services or goods are bundled into the Physician Fee Schedule payment, or (2) as otherwise specified in the Physician Fee Schedule.

Procedure Coding

Procedures are generally coded using the AMA CPT® codes. Exceptions are specified in the fee schedule regulations. The CPT® resource manuals are published annually and may be purchased online at the [AMA website](#).

Diagnostic Coding: ICD-10

One of the most important parts of the workers' compensation system claims process is diagnostic coding. Effective October 1, 2015, the DWC requires conversion from the International Classification of Diseases (ICD) 9 codes to the updated ICD-10 codes. Although workers' compensation is technically exempt, the DWC is requires conversion to ICD-10 to align with industry standards.

California Specific Codes

The regulations also include workers' compensation-specific codes developed for California. Physicians and nonphysician practitioners must use the "California Specific Codes" (see Table 13.2). Maximum reasonable fees for these services can be no more than the fee listed in 8 CCR § 9789.19, by date of service. The fees are updated annually in accordance with the Medicare Economic Index.

Table 13.2: California Specific Codes

CA Code	Procedure
WC001	Doctor's First Report of Occupational Illness or Injury (Form 5021) (8 CCR § 9789.14(a)(1))
WC002	Primary Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with 8 CCR § 9785) (8 CCR § 9789.14(b)(1))
WC003	Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14(b)(2))
WC004	Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (8 CCR § 9789.14(b)(3))
WC005	Psychiatric Report requested by the WCAB or the Administrative Director, other than medical-legal report. Use modifier -32 (8 CCR § 9789.14(b)(4))
WC006	[Reserved]
WC007	Consultation Reports Requested by the Workers' Compensation Appeals Board or the Administrative Director (Use modifier -32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (8 CCR § 9789.14(b)(5)). (Use modifier -30)
WC008	Chart Notes (requested by the claims administrator) (8 CCR § 9789.14(c))
WC009	Duplicate Reports (8 CCR § 9789.14(d))
WC010	Duplication of X-Ray
WC011	Duplication of Scan
WC012	Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.

Ground Rules

The [Physician Fee Schedule regulations](#) contain payment rules that affect the maximum allowable fee, such as the following:

- Multiple Procedure Payment Reduction (MPPR) for physical medicine/chiropractic/acupuncture
- Multiple Procedure Payment Reduction (MPPR) for surgery
- [Surgery global period](#)
- Multiple Procedure Payment Reduction (MPPR) for Radiology Diagnostic Imaging
- Anesthesia time calculation
- Health Professional Shortage Area (HPSA) 10% bonus
- [National Correct Coding Initiative Edits](#)

The regulations include payment ground rules that differ from Medicare as appropriate for workers' compensation.

Fee Calculation

The [Physician Fee Schedule regulations](#) contain the formulas needed to calculate the maximum fee for a procedure:

- 8 CCR §9789.12.2 sets forth the formulas for services other than anesthesia;
- 8 CCR §9789.18.1 sets forth the formulas for anesthesia services;
- 8 CCR §9789.19 sets forth important information (e.g., conversion factors) and links to data files (e.g., RVU file) needed to calculate a fee, based on dates of service. Applicable ground rules must be applied to determine the final fee. The Physician Fee Schedule [FAQs](#) contain examples of how to calculate a fee.

Contracted Fees

A medical provider and a contracting agent, employer, or insurance carrier may contract for rates different from those in the fee schedule. In such case, the Physician Fee Schedule would not apply to the service; the contract would govern the fees.

Standardized Paper Billing and Electronic Billing

The DWC has adopted regulations for standardized paper billing forms and electronic billing standards. The medical provider may choose whether to submit paper bills or electronic bills. Medical providers—including hospitals, doctors, pharmacists, and others who provide medical services and goods to injured workers—are increasingly recognizing the benefits of using electronic methods to send their bills to payors.

The regulations streamline paper billing by standardizing billing forms and make it easier to communicate through the use of standardized bill review messages. Paper bills for medical treatment provided by health-care providers and health-care facilities must be submitted on billing forms set forth in the [California Division of Workers' Compensation Medical Billing and Payment Guide](#) found on the DWC Website. All medical bills must conform to the provisions of this medical billing and payment guide, which includes coding, billing standards, timeframes and other rules.

Bills for medical treatment provided by health-care providers and health-care facilities may also be submitted electronically to the claims administrator for payment. Electronic bills must conform to the applicable provisions of the [California Division of Workers' Compensation Medical Billing and Payment Guide](#) and the [California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide](#). Medical providers may develop their own in-house e-billing capability or may contract with a bill-processing service. The DWC has posted the names of [billing service providers](#) who have asked to be listed. Note that these billing service providers have not been evaluated by the DWC, and the listing is not an endorsement. Other companies not listed may be equally capable of providing electronic billing/ bill-processing services or products.

Legally authorized billing agents and assignees must submit bills in the same manner that the original rendering provider or facility would be required to do if the bills had been submitted by the provider or facility directly.

Paper Billing Forms

Services are billed using the forms listed in Table 13.3.

Table 13.3. Paper Medical Billing Forms

Form Name	Use
Form CMS-1500	Health-care providers
American Dental Association, Version 2006 ADA 2006 Dental Form	Dentists
CMS Form 1450 or UB-04	Facilities
National Council for Prescription Drug Programs (NCPDP) Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF)	Pharmacies

Electronic Billing Formats

All health-care providers, health-care facilities, and billing agents/assignees providing medical treatment may electronically submit medical bills to the claims administrator for payment. California workers' compensation utilizes the standards of the Accredited Standards Committee (ASC X12), which are the same national standards used for billing by entities covered by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Detailed information, including electronic billing regulations and guides, can be found at the [DWC electronic billing web site](#).

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Administrative Simplification Act provisions of HIPAA do not apply to workers' compensation because the federal statute exempts it from its coverage. However, the California legislature has directed that workers' compensation electronic billing standards be consistent with HIPAA where feasible.

Payment Timeframes

The claims administrator should make the payment to the provider for a paper bill within 45 days of receipt of the bill and supporting documentation/reports and within 60 days for government agencies. Electronic bills are paid within 15 days of receipt of the bill and supporting documentation. Please see [California Division of Workers' Compensation Medical Billing and Payment Guide](#) for further details.

Resolving Billing Disputes: Request for Second Review and Independent Bill Review

Request for Second Bill Review—90-Day Time Limit

After an Explanation of Review (EOR) is received from the payor on an original bill submission, a medical provider or billing agent/assignee who disputes the amount paid may submit an appeal/reconsideration/request for second review to the claims administrator within 90 days of service of the explanation of review.

The Request for Second Review must conform to the requirements of the [California Division of Workers' Compensation Medical Billing and Payment Guide](#) and regulations at [8 CCR § 9792.5.4](#) et seq. If the dispute is the amount of payment and the health-care provider billing agent/assignee does not request a second review within 90 days of the service of the explanation of review, the bill is deemed satisfied, and neither the employer nor the employee is liable for any further payment.

There are two options for indicating that a Second Bill Review is requested on medical treatment bills only: (1) by submitting a modified standardized billing for using predefined fields, or (2) by completing the form "Provider's Request for Second Bill Review" (Form SBR-1). Use of this DWC form is required for medical-legal bills.

When a Request for Second Bill review is submitted, it is critical to include any additional documentation or substantiation supporting the billing statement along with the request. The payor's Final EOR Determination will be based on the documentation submitted. The request may be mailed or faxed to the claims administrator.

If the provider disagrees with the outcome of the second review, they may request resolution of the dispute through the Independent Bill Review (IBR) process within 30 days after service of the second review decision (see below). IBR cannot be requested until after the claims administrator issues a decision following a timely requested second review and the medical provider disagrees with the second-review decision.

Independent Bill Review (IBR)

Medical treatment and medical-legal billing disputes are resolved through IBR, an efficient, nonjudicial process. A medical provider who disagrees with the amount paid by a claims administrator for an authorized service on a properly documented bill may apply for IBR. The DWC contracts with an independent bill review organization (IBRO) to conduct the reviews. Maximus Federal Services currently serves as the IBRO. IBR applies to any medical service bill for which the date of service is on or after January 1, 2013, and the fee is determined by a [fee schedule](#) established by the DWC. A complete description of the program, including necessary DWC forms, is available on the [DWC website](#).

IBR Application

To request IBR, the medical provider must submit [an application for IBR](#) either electronically or on paper. An application for IBR can be completed and submitted electronically by [registering as a user](#). The provider is responsible for submitting a check or money order for the IBR fee and any required or supporting documentation as part of the paper application within 30 days after receipt of the second-review decision.

Review of Eligibility and Assignment

The IBRO receives the application, creates the case record, and conducts a preliminary review of eligibility. Criteria for eligibility include:

- Is the application signed and dated by the provider?
- Has the filing fee been paid?
- Was the billed service authorized?

- Was the application received within 30 days of the claims administrator’s final determination?
- Did provider submit the Second Bill Review final determination?
- Is the dispute covered under a fee schedule?

IBR Decision

After a case is determined to be eligible for IBR, it is assigned for review within 15 days. Assignment notices are sent to the provider and claims administration, and the 60-day clock begins for issuance of a final determination. Ineligible cases also receive notification, and the provider is reimbursed for a portion of the fee. The IBRO reviews the submitted documentation using the OMFS codes in place at the time of service and makes a determination regarding payment for services. If the provider prevails, the claims administrator must reimburse the provider for the IBR fee.

Withdrawals

The IBR application may be withdrawn at any time prior to determination. If the request is withdrawn prior to its assignment to an IBRO for IBR, the fee is fully reimbursed, but if the request is withdrawn after its assignment to an IBRO for IBR, the fee will not be reimbursed.

Consolidation

“Consolidation” means combining two or more requests for IBR for the purpose of having the payment reductions contested in each request resolved in a single determination. Separate requests for IBR must be submitted as part of the initial IBR request and must meet criteria specified in the [IBR regulations](#).

Appeals

A provider or claims administrator may appeal a final IBR determination issued by Maximus or a decision by the administrative director that an IBR application is not eligible for review. An appeal of either decision must be filed with the local district office of the Workers’ Compensation Appeals Board (WCAB) no later than 20 days after service of the determination. In addition to other [WCAB requirements](#), the “Petition Appealing Administrative Director’s Independent Bill Review Determination” must be served on the DWC’s IBR Unit. The petition will not be placed on the calendar and adjudicated by a Workers’ Compensation Administrative Law Judge unless a declaration of readiness is filed.

Chapter 14

Monitoring Compliance with the Rules and Enforcement of Compliance

Key concepts:

- Oversight of Claims Administrators
- Oversight of Utilization Review
- Oversight of Medical Provider Networks
- Oversight of Health Care Organizations
- Oversight of Qualified Medical Evaluators

Claims Administrator Audits

The DWC Audit and Enforcement Unit conducts audits of claims administrators to determine whether they have met their obligations under workers' compensation laws. These obligations include the correct and timely payment of benefits to injured workers and correct and timely payments to medical providers. The Audit Unit performs random and nonrandom audits; it also receives and evaluates complaints from injured workers and medical providers concerning practices by claims administrators.¹⁶ The Audit Unit has offices in Los Angeles, Oakland, and Sacramento.

As noted above, claims administrators are subject to investigation and penalties. Claims administrators are normally subject to routine investigations once every five years. These routine investigations for claims administrators are carried out in conjunction with the profile audit review (PAR) audits conducted in accordance with [Labor Code § 129](#). The Audit Unit reviews a random sample of requests for authorization during an investigation. The sample is drawn from the requests submitted in the three-month calendar period prior to the commencement of the investigation. Of the entire population of requests submitted, only those meeting the regulatory definition of a request for authorization are used in the investigation.

The claims administrators receive notice that they have been selected for investigation. After producing the information requested for the investigation, the claims administrators receive a notice of investigation commencement at least 14 days before the investigation begins. The investigation of claims administrators takes place at the adjusting location. After the investigation has concluded, a final investigation report (which includes a performance rating) is provided to the investigation subject.

If a claims administrator fails a routine investigation, the DWC can return for a targeted investigation. The DWC can also conduct a targeted investigation based on a credible complaint. Credible complaints may be provided to the claims administrator for their response prior to an investigation.

As each investigation is completed, the final performance rating and an analysis of penalties or violations cited are posted by the DWC.

Utilization Review Investigations

Utilization review organizations (UROs) are subject to UR investigation and penalties. UROs are subject to routine investigations once every three years. The DWC Medical Unit reviews the plans of

¹⁶ [Forms](#) to make complaints to the Audit Unit or about UR or QME issues are available on the DWC website.

UROs to confirm that the plans comply with the relevant regulations. The DWC periodically investigates UROs to determine whether responses to physicians' requests for treatment are timely, whether content of the responses complies with regulations, and whether review letters are distributed to the appropriate parties. The UROs receive notice that they have been selected for investigation. After producing the information requested for the investigation, the UROs receive a notice of investigation commencement at least 14 days before the investigation begins. The URO provides copies of all requested documents to the DWC Medical Unit. Administrative and civil penalties are assessed if required. If a URO fails a routine investigation, the DWC can return for a target investigation. The DWC can also conduct a target investigation based on a credible complaint. Complaints concerning practices by UROs are received and reviewed as part of routine investigations of them.

Results of [audits and investigations of claims administrators and UROs](#) are publicly available.

Oversight of Medical Provider Networks and Health Care Organizations

For MPNs to be approved and for HCOs to be certified, they must comply with regulations that (1) require employee notifications about what procedures to follow when workers are injured; (2) require MPNs or HCOs contain sufficient numbers of physicians and the appropriate distribution of medical specialties to care for employees of an employer that has contracted with a network or organization; and (3) require that an organization's lists of medical providers are current. MPNs that do not comply with the regulations will not be approved, and the approval of an established MPN or certification of HCO that is found to be out of compliance may be revoked.

Qualified Medical Evaluator Oversight

The DWC Medical Unit receives complaints from the public, including injured workers, attorneys, and claims administrators, about the behavior of doctors who have been appointed as QMEs. Judges may report instances in which QME reports do not contain substantial medical evidence, that is, are unsatisfactory in terms of providing the information that a judge may need to resolve a dispute arising in the workers' compensation system. Judges may also make referrals to DWC Medical Unit for any QME who has violated any of the regulations that govern the QME process. The QME Medical Unit evaluates and investigates these complaints and judges' referrals and may pursue disciplinary action such as a formal reprimand, suspension of the QME appointment, or revocation of a physician's QME status.

Discipline of Qualified Medical Evaluators

The appropriate behavior of QMEs is governed by statute and regulations. QMEs in violation of these requirements may be subject to a range of disciplinary action. The DWC believes that education is the most effective course of action in resolving less serious regulatory violations. Discipline may be considered for serious misconduct. The guidelines described in [8 CCR § 65](#) provide a framework of the disciplinary process. These guidelines are not intended to be an exhaustive list of violations or disciplinary actions that may be considered against any QME. Any violation of statutory or administrative duties may constitute grounds for discipline under these guidelines. Although the guidelines are intended to establish consistency in imposing disciplinary sanctions for similar offenses, mitigating or aggravating circumstances in a specific case may necessitate variation from these guidelines.

In order to oversee the appropriate legal and ethical conduct of QMEs, the DWC Medical Director or his or her designee is delegated authority to conduct investigations, issue subpoenas, file requests for hearing, and perform many other functions related to QME discipline. Final decisions regarding formal disciplinary action against a QME are made by the AD.

Grounds for a physician's suspension or termination from the QME list without a hearing include:¹⁷

- (1) having a license that has been revoked
- (2) having a license that has been suspended or terminated by the relevant licensing board so as to preclude practice
- (3) being convicted of a misdemeanor or felony related to the conduct of one's practice or being suspended or placed on probation by the relevant licensing board
- (4) being put on probation, based on a stipulation or a decision by the physician's licensing board
- (5) failing to pay the appropriate fee on time as required under 8 CCR § 17.

Any QME found in violation of a statutory or administrative duty may be suspended, terminated, or put on probation following an administrative hearing for violations that include, but are not limited to:

- (1) a violation of Labor Code § 139.3 (referral to someone with whom the physician shares a financial interest) or Labor Code § 4628 (includes signing medical-legal report, billable amounts, contempt)
- (2) failure to follow the medical procedures established for QMEs (Labor Code §§ 139.2(j)(1)(2)(3)(4)(5) or (6))
- (3) failure to comply with the QME appointment requirements of Labor Code § 139.2(b) or (c) or 8 CCR §§ 10, 10.5, 11 or 12
- (4) failure to comply with the unavailability notification requirements (8 CCR § 33)
- (5) failure to comply with the disclosure, ethical or conflict of interest requirements pursuant to 8 CCR §§ 40, 41 or 41.5
- (6) failure to complete accurate and complete reports pursuant to Labor Code § 139.2(i) or 8 CCR § 39.5
- (7) a finding by the WCAB of ex parte contact by the QME prohibited by Labor Code § 4062.3
- (8) a finding by the AD that the QME solicited an injured worker to take over that worker's treatment for his or her workers' compensation claim
- (9) failure to disclose a disqualifying conflict of interest (8 § CCR 41.5)
- (10) failure to disclose a significant financial interest, as defined in 8 CCR §§ 1(cc) and LC 139.3.

Treating Physicians

The DWC has no direct oversight of treating physicians or medical providers. Issues related to fraudulent billing or other aspects of provider fraud should be referred to the relevant licensing body for a physician and to the Insurance Commissioner and Attorney General or a district attorney.

¹⁷ A QME may appeal the suspension or termination order with the state court.

Employers

The DWC does not have oversight of employers' compliance with regulations related to obtaining workers' compensation insurance for employees; these kinds of issues are addressed by the Division of Labor Standards and Enforcement and the Department of Insurance.

Chapter 15

Physician Conduct and Ethics Involving Medical-Legal Evaluations

Key concepts:

- Conduct and Ethical Issues for Medical-Legal Evaluating Physicians to Consider
- Regulations on Conduct to Curb Fraud and Abuse
- California HIV/AIDS Laws—Workers' Compensation
- Fraudulent Workers' Compensation Claims
- Appropriate Advertising for QMEs

The Physician's Conduct

Introduction

Most physicians are conscientious about working ethically within the workers' compensation system, and they are careful to treat their patients with fairness and respect. However, the workers' compensation system is often an adversarial system, with large amounts of money or other benefits at stake. Physicians also may know or have business relationships with some of the parties involved. It is easy for the appearance of impropriety to develop. Charges of fraud and abuse have been well publicized in the media, along with some proven cases of highly unethical and illegal behavior by a few physicians, clinics, or medical groups.

To rectify this situation, the legislature has attempted to clarify and codify the role played by the medical-legal evaluating physician. The Labor Code (and regulations) now address the length of time doctors should spend with patients, where the exams should take place, what kinds of referrals are allowed, what constitutes appropriate advertising, and many other aspects of the medical-legal evaluating physician's conduct.

This chapter covers some of the broader conduct and ethical issues that all medical-legal evaluating physicians need to consider, as well as the regulations on conduct that have been developed specifically to curb fraud and abuse in the system. Although most of the standards and regulations focus on QMEs, we first look at some of the issues faced by treating physicians, who also serve as evaluators in the workers' compensation system.

Treating Physicians as Evaluators

Treating physicians must balance several roles. According to the American College of Occupational and Environment Medicine Code of Ethics, the treating physician's first responsibility is to the patient (<https://www.acoem.org/codeofconduct.aspx>). Treating physicians are also required to render opinions on medical issues needed to determine eligibility for compensation (Labor Code § 4061.5). The treating physician has been given this role because of an existing relationship with the patient and knowledge of the patient. Thanks to the treating physician's knowledge, injured workers will need fewer medical exams and should be able to settle their cases more quickly. This should also reduce medical-legal costs in the workers' compensation system. (For a broader discussion of the treating physician's role, see Chapter 6.) The primary treating physician may choose to desig

Box 15-1. Unique Role of the Treating Physician in Workers' Compensation

In most areas in clinical medicine, the treating physician serves as the “patient advocate.” However, for workers' compensation purposes, the physicians should be as objective as possible.

—Medical Causation Analysis: Suggested Guidelines for California Workers' Compensation

Box 15-2. Let the Injured Worker Know You Care

When I went to the QME, it felt like a project. It was a drag. I felt like a product or something he had to get done with to get me out of there. He interrupted me, he'd ask me a question, and I would try to answer it as well as I could, and he kept interrupting me. It was like he didn't care. ... My regular doctor was much more interested. ... This guy was trying just to write his report. He was kind of cold.

—an injured worker

nate another physician to prepare a patient's final permanent and stationary evaluation (Labor Code § 4061.5). (For the format of a permanent and stationary report, see Chapter 7.)

A treating physician is required to complete a final report on all medical issues necessary to determine the patient's potential eligibility for benefits.

- The report will in many aspects resemble a medical-legal report with some key differences.
- The report must include the information on the PR-3 or PR-4.
- The report will not be generated as the result of a disputed issue (as would a QME's report).
- The Primary Treating Physician's Progress Report (PR-2), the Primary Treating Physician's Permanent and Stationary Report (PR-3 or PR-4), and a Psychiatric Report requested by the WCAB or the administrative director (other than medical-legal report) are reimbursable separately pursuant to 8 CCR § 9789.14. Other treating physician reports are not reimbursable separately as the appropriate fee is included within the fee for the underlying evaluation and management service.

The Scope of the Exam

Evaluators are asked to render an opinion on all disputed medical issues and to perform a comprehensive medical-legal evaluation within the scope of their field of competency. “Comprehensive” does not mean, however, that a battery of irrelevant information should be collected. Sexual history questions, for example, are not usually appropriate unless the claim involves sexual harassment, sexual assault, or sexual battery. Even in these cases, there are now **strict limitations on the sexual history** evidence that can be gathered or admitted to contest a claim (Labor Code § 3208.4). In some instances (e.g., severe, chronic pain), evaluation of substance abuse and emotional/psychological factors are relevant. **Releases** are commonly used by physicians and carriers to obtain all industrial and non-industrial records about the worker. These releases are permissible, and in most cases the information is released to the carrier. However, **if workers refuse (as is their right), the issue must be litigated before the WCAB.** Remember, all aspects of comprehen-

Box 15-3. A QME's Perspective

I can appreciate the fact that the injured worker may be nervous about the exam and want someone there for moral support. On the other hand, I want to hear in the patient's own words information crucial to my exam. Sometimes spouses or friends want to participate in the exam, which can become a problem.

— a Qualified Medical Evaluator

sive medical-legal evaluations, including taking a medical history, must be directly related to medical issues in the case.

Whenever possible, the physician should try to discuss the scope of the exam with the injured worker *prior* to beginning the actual exam. If a worker questions the scope of the exam, the physician should explain the need for the information being requested. The physician should try to avoid taking a defensive stance and simply answer these questions as reasonably as possible.

What Are the Legal Responsibilities of the QME When Conducting a Medical-Legal Evaluation?

Labor Code § 4628 contains the Evaluator's Disclosures regarding the work performed during medical-legal evaluations. The physician who signs the report must personally:

- examine the applicant,
- take a thorough history,
- review and summarize all prior medical records,
- compose and draft the conclusions of the report.

The physician is responsible for reviewing the entirety of the medical record. In some cases, the physician may have an assistant make an initial outline of the patient's history or take excerpts from prior medical records to prepare the physician for personally taking a complete history or summarizing the records. However, the physician must report the name of the person performing these functions and the person's qualifications to do so. (These tasks should never be delegated for psychiatric evaluations.) The physician must review the excerpts and outline with the patient and make any necessary additional inquiries. The physician can also assign other trained and qualified individuals to perform diagnostic tests. The name, qualifications, and role of anyone involved in making outlines or excerpts, in performing diagnostic tests, or in drafting the report must be disclosed in the report.

The Physician's Perspective

The goal of the medical-legal evaluation exam is to collect and interpret all the information necessary to provide evidence about a worker's claim. The evaluator may want to take a few minutes at the beginning of each examination to discuss issues such as their role, confidentiality, and the absence of the usual doctor-patient relationship. 8 CCR § 40 mandates that a **QME performing a medical-legal evaluation of an unrepresented worker must inform the injured worker of his**

Box 15-4. Overhead Is Included in Medical-Legal Billings

The Appeals Board, in a panel decision, has held that you may not bill separately for clerical costs incurred in generating a medical-legal report. The panel interpreted Labor Code section 4628 (d) to provide for all included fees within the billings.

—Mission Hills Medical Group v. WCAB (1997) 62 CCC 539.

or her right to ask certain questions about the evaluation process and about the evaluator's background.

In order to conduct a fair exam, the physician should try to understand why the injured worker may not always be forthcoming. Workers may well be hostile, apprehensive, nervous, or evasive during the exam because they may not trust the impartiality of the QME.

The QME is being asked to give an objective opinion about the worker's condition. The evaluator should review all available medical and nonmedical records and facts before writing the report. The QME should render opinions or conclusions only about issues for which they have had adequate education and training (8 CCR § 41). A workers' compensation **judge will decide disputed issues and will determine the weight to give to conflicting histories or evaluations.** If the worker tells the QME something that is inconsistent with previous findings or records, the evaluator should ask the worker about it. Seeming inconsistencies are often the result of miscommunication between the worker and other physicians. The QME should quote the worker as accurately as possible and try to assess the discrepancies and attempt to explain them within the context of the evaluation.

Interpreters

For all evaluators, if the worker being examined is not proficient in English, and the QME is not proficient in the worker's native language, the worker is entitled to have a certified interpreter and the employer/insurance company must pay for it (Labor Code § 5811). (A worker is also entitled to have an interpreter during treatment visits [Labor Code § 4600]). In cases where the worker who needs an interpreter is unrepresented, the QME should notify the employer insurance carrier of the need for an interpreter. (See the [QME Appointment Notification Form 110](#).) It is the responsibility of the carrier to arrange for a "certified" interpreter. In the report, the evaluator should mention that a certified interpreter was used, and his or her name should be provided. It is important for the interpreter to be able to accurately relay to the physician what the worker is saying about work history, symptoms, and other information, as well accurately interpreting the physician's questions and information.

Even if a worker speaks some English, it may be easier to communicate in the worker's native language, in which case an interpreter should be provided.

Can Injured Workers Bring Someone to the Exam?

For a basic medical-legal evaluation, the injured worker may have someone present during the entire examination, unless the physician has an overriding reason not to allow that person to be present for some portion of the exam. This person can be a friend, relative, union representative, a court reporter (see *Fireman's Fund v. WCAB* (1980) 45 CCC 37), or other support person who is

Box 15-5. Accompanying an Injured Worker to the Medical-Legal Evaluation

In *City of Garden Grove v. WCAB* (1988) 53 CCC 192, the WCAB was upheld in affirming an injured worker's right to have a court reporter present to record his evaluation. The workers' compensation judge cited the fact that civil actions allow for such practice, as does Labor Code § 4052.

The Board's decision in *Fireman's Fund v. WCAB* (1980) 45 CCC 37 also upholds the injured worker's right to have a witness present at the exam.

Box 15-6. Counsel's Right to Be Present at Psychiatric Evaluations

Civil law allows a claimant's attorney to be present at evaluations set by the opposing party (Code Civ. Proc. § 2032). On two occasions, however, the Supreme Court of California has held that this right applies only to physical evaluations (see *Sharff v Superior Court* (1995) 44 Cal.App. 2d 408) and does not extend to psychiatric evaluations. In upholding its decision in *Edwards v Superior Court* (1976) 16 Cal.App. 3d 905, the high court held that the psychiatric evaluator must have the ability to examine the plaintiff's psyche without interference by a third party. Counsel's presence offered no specific safeguard because a physician can always be deposed and "the attorney's comforting presence was outweighed by the distraction and potential disruption to the evaluator."

there at the request of the injured worker to provide comfort and reassurance during the exam. The support person should not create an adversarial relationship between the QME and the injured worker. For example, if the person accompanying the patient disrupts the exam, the evaluator should discuss this with the injured worker and explain why this person should not be present during parts of the examination. (Note this does not mean the injured worker may have his or her attorney present during a psychiatric exam. However, an attorney or a court reporter may be present at nonpsychiatric exams.)¹⁸

It should be noted that all of the cases applying former Code of Civil Procedure §2032 dealing with the right to have an attorney, court reporter, or other person present at the exam, and the cases having to do with recording of the exam being within the discretion of the court, are based on the parameters of civil discovery, in which a partisan expert witness is conducting the exam. This rationale also applies to the QME program prior to 2004, when each party was entitled to get his or her own QME. At that time, the QME was in fact acting as a partisan expert witness, and therefore the examinee's rights needed to be protected.

Since 2004, the QME has been assigned by a random process controlled by the DWC. Based upon this change in the factual circumstance surrounding assignment of the QME, the QME is no longer acting as a partisan expert witness but, rather, as an objective evaluator. Therefore, the decisions and reasoning for the decisions in the cases cited may no longer apply.

¹⁸ In *Penman v WCAB* (1995) 60 CCC 793, a WCAB panel held that an attorney can be present only if bias is indicated. If the physician believes that the attorney's presence would disrupt the exam, the attorney should not be present. (This is a writ denied decision, however, and carries little authority in that it does not have precedential authority. This means that the holding in the case applies to the facts of the specific case before the court. The legal conclusion in the case can be considered by judges in subsequent judicial proceedings, but they are not **required** to follow the holding in the case.)

Can Injured Workers Record the Exam?

In some cases, injured workers may wish to make an audio recording of the examination. This is a very unsettled area of law, and there is currently no statute or regulation that prohibits this practice. In the case of *Brewer v. WCAB* (1986) 51 CCC 190, an unpublished decision, the appellate court held that an injured worker is allowed to videotape a psychiatric exam.

However, pursuant to Penal Code § 632, a private communication cannot be recorded without the consent of **both** parties. Therefore, if the evaluator does not wish to have the evaluation recorded, we are aware of no statutory or regulatory authority that would require them to allow the recording. Therefore, currently the permissibility of recording is an open question. The DWC advises a QME that if someone wants to record the examination, the person should make this known prior to the examination so that the physician can either agree or disagree to having evaluation recorded. This also allows either party to communicate any authority the person has that indicates the recording process should go forward or bring the issue before a WCJ.

Given the unsettled nature of this area of the law, it is not unreasonable for the QME to require a court order before going forward with an evaluation that one of the parties wants to record or videotape or at which an attorney or court reporter will be present. This request should be communicated to the parties as soon as a QME is made aware of the intent to record, videotape, or invite other parties.

Inappropriate Remarks/Joking

Can an injured worker secretly record his or her evaluation and use “off the record” comments made by the QME as evidence? General comments made by the QME during the exam are not “confidential” because the QME is reporting to a third party. QMEs should never assume their statements are “confidential” because the injured worker is present as a result of litigation. Although it is clear that Penal Code § 632 would definitely apply to “secret recordings,” the safest approach is not to engage in any “off the record” or casual discussions of controversial or unrelated subject areas. Many workers have filed complaints with the Medical Unit over casual comments construed by the worker as insulting or inappropriate, even when that was not the intent of the physician.

The Length of the QME Exam

The DWC has established guidelines on the amount of time an examiner should spend with a worker in face-to-face contact when conducting different types of evaluations. For example, during a psychiatric evaluation, the evaluating physician must spend a minimum of one hour in direct face-to-face contact with the patient. A psychiatric evaluator more typically will spend two to three hours with the patient. (For exact requirements, see Chapter 12.)

The result of the time that the QME spends with workers may have a significant effect on their lives, including access to the kinds of resources needed to recover from the effects of the injury. Physicians who elect to participate in the medical-legal evaluation process by performing exams have a moral and professional responsibility to spend adequate time to collect and clarify all the information necessary to develop a complete and objective report, regardless of reimbursement issues.

When Can a QME Exam Be Terminated?

The DWC has enacted ethical guidelines that provide ground rules on when an exam can be terminated by either an injured worker or a QME (8 CCR § 40-41).

An injured worker may not be kept waiting for more than an hour after the scheduled appointment time. If an unrepresented worker is kept waiting for more than an hour, the worker may terminate the exam and ask for a new QME (8 CCR 41(f)). No one is obligated to pay physicians for their time in this circumstance. They may explain the reason for the delay, and, if the worker agrees, the exam may be rescheduled, **The physician must inform the claims administrator of the new appointment time within five days of rescheduling the appointment.**

The injured worker may discontinue the exam because of discriminatory conduct by the evaluator toward the worker based on race, sex, national origin, religion, or sexual preference, as well as instances in which the evaluator asks the worker to submit to an *unnecessary exam or procedure* as it relates to the injury medically. Discriminatory conduct includes improper sexual advances by a physician.

Initially, the decision to terminate the exam based upon any of the above violations of 8 CCR §§35(k), 40, 41(a) or 41.5 is within the discretion of the injured worker at the time the exam is being conducted. However, pursuant to §41(g) if a judge later finds there was no good cause for the termination, the cost of the evaluation is deducted from the injured worker's award.

However, the QME is not obligated to complete an exam if the injured worker:

- uses abusive language.
- is disruptive (8 CCR § 41 (h)).
- deliberately attempts to disrupt the operation of the physician's office in any way.
- **is intoxicated** or under the influence of any substance that impairs his or her ability to participate in the process.

Can a Medical-Legal Evaluating Physician Become a Treating Physician?

There is a process in which the QME can actually become the treating physician. However, some considerations should be taken into account before arriving at that juncture.

Occasionally, a QME may determine in the course of a disability evaluation that a worker's condition is not yet permanent and stationary. It is the QME's responsibility to conduct as thorough and objective an evaluation as possible and to make an honest assessment of an injured worker's status based on all available medical evidence. If the QME disagrees with the treating physician's assessment that a worker has medically stabilized and that the worker's condition is permanent and stationary, the QME report should:

- Discuss the basis for a determination that a worker's condition is not permanent and stationary;
- Identify any additional treatment that may contribute to additional medical improvement;
- Provide an estimate of the date by which the worker's condition is likely to be permanent and stationary.

The QME may not offer to provide additional treatment to the injured worker. In some cases, a worker may choose, after undergoing a QME evaluation with a physician, to formally request that

the QME take over his/her treatment. This is permissible. The Labor Code gives injured workers the right to choose their treating physician (after the initial 30 days), unless they have opted to participate in an employer-offered HCO (Labor Code § 4600.3). After proper notice to the employer by the employee, the QME may provide the treatment or may choose to refer the worker to another physician. If the QME does agree to become the PTP, there may be a requirement that the QME be or become a member of the employer's medical provider network before he or she can legitimately provide treatment to the injured worker. If the QME does agree to become the PTP, he or she will prepare a PTP's report at the appropriate time. If a new QME examination becomes necessary, a new panel may be requested or a new QME may be chosen, depending on the situation.

In summary, a physician may not perform a medical-legal evaluation concerning an injury for which the physician has become the PTP unless specifically requested to address a disputed issue. However, in addressing the disputed issue the former QME physician will be acting as the PTP and not in the role of a QME. Again, a new QME must be selected if any QME evaluation is required.

With Whom May a Physician Communicate When Conducting an Evaluation?

A basic principle in a fair legal system is that all parties have equal access to nonprivileged information. Regulations concerning **ex parte communication** ("done for, on behalf of, or on the application of, one party only") by evaluating physicians are meant to help maintain the neutrality of the physician's role and to ensure that all parties are equally informed. It is important for physicians to understand the concept of ex parte communication and to abide by these laws and regulations. Ex parte communication can be communication from the parties to the QME or communication from the QME to the parties. Communication initiated by the physician can also constitute ex parte communication; and in no event should there be ex parte communication of any kind that violates Labor Code §4062.3(e). For example, in *Alvarez v. Workers' Compensation Appeals Board* (2010) 187 Cal.App.4th 575, the court held that it was impermissible ex parte communication for the QME to call the defense attorney to ask for another copy of the records. Under 8 CCR § 35 (d), QMEs are prohibited from viewing nonmedical records or films if a party objects.

However, treating physicians are required to view and comment on videos relevant to the claim (*Estrada v. Encino Hospital* (1999) 27 CWCR 167).

For QMEs

In panel QMEs, the evaluator is not allowed to communicate with either party outside the evaluation exam, except in writing, and any written communication must be served on the opposing party within 20 days (Labor Code § 4062.3(e)). The QME may contact the employer/insurer solely to request the medical records. However, that contact should be in writing with a copy served on the injured worker or the injured worker's attorney.

For AMEs

Parties must agree before the exam which information the physician will see. The 20-day rule for communication with QME no longer applies to AMEs. See Labor Code § 4062.3(f).

For Treating Physicians

Treating physicians often have communication with outside parties regarding a specific case. Usually this involves the employer or the workers' compensation carrier or adjuster. The purpose of these conversations is to expedite the handling of specific aspects of the claim, usually early in the process. Like QMEs, treating physicians should try at all times to maintain neutrality when communicating with outside parties and should limit this communication to discussion of information pertinent to the worker's case. When a treating physician takes on the role of medical-legal evaluator, he or she should follow the same guidelines for communication as those that apply to the QME.

Referrals and Diagnostic Tests

When a QME/AME Evaluation Is Conducted, When Is It Appropriate to Make Referrals or to Request an Additional Test?

On occasion, additional diagnostic tests may be necessary to reach a conclusion about a patient's condition. The law is very specific about which kinds of referrals are allowed and when additional diagnostic tests will be considered. Increased scrutiny of unnecessary medical testing and UR to determine the correct mix and number of diagnostic tests are now common throughout medical practice. The workers' compensation system is no exception.

Is the Test Necessary?

The physician must decide which kinds of tests are "reasonable and necessary" ***to prove the contested claim***. The physician should also carefully consider the need for repeating any diagnostic tests that have already been conducted. For example, it may be important to compare results from the same test taken at different times, or the evaluator may question the results of a test that are inconsistent with other findings. However, the evaluator must explain the reasons for the repeat testing in the medical-legal report, and the prior results must be available for comparison.

Will the Evidence Be Relevant to the Dispute?

Diagnostic tests that will not produce relevant information for the contested claim will not be reimbursed as a medical-legal expense.

The only valid justification for diagnostic testing as medical-legal is that the evaluating doctor needs the results of the testing in order to reach an opinion regarding a disputed aspect of applicant's case. The mere performance of a given test does not give rise to a right to payment as a medical-legal lien claim. The results of the test must be summarized in a written report, and that report must be reviewed and in most cases commented upon by the evaluating doctor, again in the form of a written report. Otherwise, those results do not constitute evidence.¹⁹

Tests performed purely to rule out various non-industrial explanations of the injury or illness are not justified either. The applicant has the burden of proof in showing that an injury or illness is

¹⁹ Honorable Pamela Foust, Retired Workers' Compensation Judge, *Handling Medical-Legal Issues: An Analysis and Proposal*, Conference of California Workers' Compensation Judges, Los Angeles (1992), pp. 15-16.

work related. Disproving possible non-industrial causes does not prove an industrial cause. Therefore, this kind of testing does not provide useful evidence to support the worker's claim.²⁰

Self-Referrals and Cross Referrals

Treating or evaluating physicians for injured workers are required to include a declaration on all bills that they were not in violation of Labor Code § 139.3 (self-referral) for services provided to the worker. Most physicians include this statement in their declaration that the contents of the report are true and correct to the best of their knowledge. The PR-3 also contains declarations. QMEs include this language in their declaration, according to Labor Code § 4628.

The Labor Code and the Business and Professions Code now contain more comprehensive provisions addressing self-referrals. These provisions were developed because some physicians had routinely referred patients for expensive and unnecessary diagnostic procedures at facilities in which they had a financial interest. Certain types of self-referrals (referrals to certain types of facilities in which the physician or the physician's family has a financial interest)²¹ are specifically prohibited. The following referrals are not allowed (with the exceptions noted below):

- Any outside referrals for the following services, in which the physician or the physician's family has a financial interest: clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging. This includes any arrangement in which the referring physician receives money from the recipient facility and physician.
- Any cross-referral arrangement or other scheme whose primary purpose is to ensure referrals (Labor Code §§ 3215, 5307.6; Bus. & Prof. § 650)—for example, if two doctors routinely refer patients to each other, even if the referrals are not always necessary.
- Any kind of compensation or inducement for referred evaluations or consultations. (For example, a physician cannot buy gifts for claims examiners as an inducement to receive referrals from that insurer.) It is now a felony to offer compensation to a claims adjuster for a referral (Labor Code § 3219).

If a physician needs to make a referral for a nonprohibited service in which that physician has a financial interest, the physician must disclose that information to the patient.

The prohibition is not intended to alter, limit, or expand a physician's ability to deliver or supervise the delivery of services or goods provided within the physician's own office or group practice. However, if the services are for physical therapy, certain psychiatric testing, or, more typically, MRIs, the physician is required to get preauthorization in writing within five days (Labor Code § 139.31(e)). Any violation of these referral prohibitions is a misdemeanor.

In the case of *Jones v Target Stores* (1998) 26 CWCR 319, the WCAB, in a significant panel decision, held that failure by a physician to obtain preauthorization for a physical therapy referral to the clinic that employed him was a violation of Labor Code § 139.3(e). The panel found that the referring physician was not in violation of the self-referral laws because he received a flat salary and received no compensation for referrals to the clinic at which he worked. Because the referral was for physical therapy, however, the referral was disallowed by the board because of the absence of preauthorization (Labor Code § 139.31(e)).

²⁰ *Ibid.*, p. 13.

²¹ Self-referral includes referrals to other persons with whom the physician shares a financial interest as well as referrals within one's own office. *Stakely v. WCAB (Toliver)* (2000) 65 CCC 596.

Also, if the physician's regular practice is outside a metropolitan area, and there are no alternatives available within 25 miles or a 40-minute drive, a physician may make referrals for services in which the physician has a financial interest, with full disclosure to the patient and the insurer/adjuster (Labor Code § 139.31(a)).

The District Attorney's office handles self- and cross-referral violations. QMEs who have questions concerning Labor Code § 139.3 should consult an attorney or contact the local DA's workers' compensation division.

Ethics

Confidentiality

Confidentiality is an important and difficult issue, especially for treating physicians who have records that may become part of a patient's workers' compensation file.²² Patients assume a certain amount of confidentiality in dealing with physicians in a traditional doctor/patient relationship. The Confidentiality of Medical Information Act (CMIA; Civ. Code §§ 56-56.37) includes strict prohibitions on the release of a patient's medical records by providers of health care in California. However, in the workers' compensation system, work injury information does not enjoy strict confidentiality. Communications between physicians and patients are turned into reports and mailed to the employer or the employer's insurance company, as well as to judges and the many others involved during the life of a claim.

A patient who has chosen a personal physician as the treating physician may have particular concerns about confidentiality, because the patient may find it difficult to treat the personal physician as a medical-legal evaluator. In addition, the treating physician may have information in the patient's files predating the work injury that the patient would not want released. The patient's medical records that are unrelated to the work-related injury *are* confidential, unless the patient signs a release form or the records are subpoenaed by the employer or other parties (Civ. Code § 56.10).

In the case of *Pettus v. Cole*, the Court of Appeal held that the employer's use of medical information in a *non*-workers' compensation case violated the worker's privacy rights under the CMIA because the court said the information released was far more than necessary to determine the worker's ability to work. The court also construed that Mr. Pettus was a "patient" of the evaluating doctors despite the fact that he was not being treated by them. Although this case was not a workers' compensation case, it illustrated the special care all physicians must use in reporting medical histories.²³

An employer, assuming it is a party to a workers' compensation case, may issue a subpoena to a health-care provider to acquire information that it holds. Nothing prevents an employer from attempting to acquire information directly from the treating doctor or the QME about the injured workers' medical condition because the information appears to be exempt from the CMIA. As a practical matter, medical practitioners who receive a valid subpoena for medical records or medical reports can probably comply unless they receive an order from a workers' compensation judge that they should not do so. Compliance in this area is complicated. The best-case scenario is to receive an authorization signed by the injured worker that will allow the physician to release the records. After a claim form has been filed, the physician should probably respond to a subpoena providing

²² The Privacy Rights Clearinghouse provides a toll-free hotline for California consumers to report abuses and request information on ways to protect their privacy: 1-800-773-7748.

²³ *Pettus v. Cole* (1996) 49 Cal. App. 4th 402, 61 CCC 975.

Box 15-7. Confidential Information and Depositions

In *Allison v. WCAB* (1999) 72 Cal App. 4th 654, 27 CWCR 129, an injured worker refused to answer a question at a deposition, contending that the information was unrelated to the compensable claim. The Court of Appeal held that the WCAB has the jurisdiction to allow either formal or informal resolutions to these disputes. The Court also suggested that attorneys can form questions more narrowly to ensure that only relevant information is obtained.

the records. However, an authorization may be necessary for the release of medical information prior to the filing of a claim, or for the release of reports that are not filed in the actual case itself. This is an issue because Labor Code § 3762 prohibits the insurer from releasing employee medical records to the employer.

Practitioners who treat workers and receive a subpoena that they believe asks for information that may not be relevant to an industrial injury may wish to discuss these issues with their patients. Physicians may also consider waiting until the day that a subpoena is due before releasing the information to ensure that no objection has been made to its release by the injured worker or their attorney before that deadline.

A valid subpoena requires that injured workers receive a copy of the subpoena to allow them or their attorney to file an objection with the WCAB if they believe that the information requested is too broad and therefore violates their right to privacy.

In a workers' compensation claim, the employer or insurance company may subpoena the treating physician for the worker's medical records. If the treating physician is also the personal physician, these records may well contain personal information that is not relevant to the particular injury or illness being considered and that the worker understandably might not want to pass on to the employer. **However, the only records that are explicitly allowed to be withheld are any psychiatric or drug treatment records, which must be directly relevant to be disclosed.** In cases in which the information is particularly sensitive, a workers' compensation judge may order this information to be sealed.

Several things can be done to help protect patient confidentiality. Treating physicians should make sure their reports are timely and complete. This may reduce the need for subpoenas, which are typically broader than necessary. Evaluating physicians should inform the employee of the confidentiality issues when conducting the exam and explain that the employer or the employer's representative will receive a copy of the report. **Physicians should include information in the report only if it provides evidence that is relevant to the worker's claim and disclose all information reviewed in the preparation of the report.** For example, insurance companies often provide the evaluator with various nonmedical records that may or may not be relevant (e.g., driving records or criminal records). **Workers have the right to review and remove from consideration by the QME any nonmedical records** (Labor Code § 4062.3(b)). However, workers are not always aware of this right and do not always take the initiative to challenge information; it is the QME's responsibility as an impartial evaluator not to be influenced by information that is not relevant and not to repeat potentially sensitive information unnecessarily.

In communications with the employer or insurer, the QME should, whenever possible, have clear records on which individual (at the employer or insurance company office) the reports will be sent to and then direct all communications to that individual.

When treating physicians become aware that they are dealing with a work-related injury or illness, they should explain the confidentiality issues to the patient. It may be advisable to es-

Box 15-8. Confidentiality

A woman in her fifties is referred for psychiatric evaluation of psychosomatic concerns seemingly related to conflict in a supervisor/supervisee relationship. She has no prior psychiatric or legal histories. In the interview she discloses aspects of her education that were misrepresented to her employer at the time of hiring. Only after asking which information is confidential, does she learn to her horror that all that she has reported will be documented. She later pleads with her attorney to drop the case and with the doctor not to file his report.

—Robert Larsen, “Ethical Issues in Psychiatry and Occupational Medicine,”
Occupational Medicine: State of the Art Reviews, Vol. 3, No. 4 (October–December 1988).

establish a separate file or separate section in the files for information pertaining to the work-related injury. Subpoenas usually specify which records are being requested. If the request is confusing or overly broad, it can be challenged by the claimant. Generally, the party issuing the subpoena will immediately clarify the request made in it. A refusal to comply with a subpoena with no legal basis may result in contempt proceedings against the custodian of records. For treating physicians who must file regular progress reports, it is doubly important to be clear about exactly which employer or insurance company representative should receive the reports. For example, while it may be appropriate to discuss a job description or potential work restrictions with the patient’s immediate supervisor, it would probably not be appropriate or necessary to discuss other aspects of the patient’s case that are not relevant to the work restrictions. The physician should be aware of the dictates of Labor Code §3762, which proscribes what the carrier can reveal to the employer. It offers a guide for the physician as well.

HIPAA

The Administrative Simplification Act provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) include requirements that national standards for electronic health-care transactions and national identifiers for Health Care Providers (Provider), Health Plans, and Employers be established by the secretary of health and human services. These standards were adopted to improve the efficiency and effectiveness of the nation’s health-care system by encouraging the widespread use of electronic data interchange in health care. HIPAA does not apply to workers’ compensation because the federal statute exempts it from its coverage. However, the California legislature has directed that workers’ compensation electronic billing standards be consistent with HIPAA where feasible.

California HIV/AIDS Laws—Workers’ Compensation

Release of Medical Information

Labor Code § 3762 and Civil Code § 56.31 relate to HIV and workers’ compensation. With identified exceptions, these statutes prohibit the disclosure or use of medical information regarding the HIV status of an employee who has filed a workers’ compensation claim without written authorization from the claimant. Exceptions include:

Box 15-9. HIV Status Is Confidential When Unrelated to the Claim

Notwithstanding any other provision of law, nothing in [workers' compensation] shall permit the disclosure or use of medical information regarding when a patient is infected with or exposed to the human immunodeficiency virus without the prior authorization from the patient, unless the patient is claiming to be infected with or exposed to the human immunodeficiency virus through an exposure incident arising out of or within the course of employment (Civil Code § 56.31).

Unlike in some states, in California the law permits patients to request copies of their medical records (Civil Code § 56.11).

- If the patient is an injured worker claiming to be infected with or exposed to HIV through an incident arising out of and in the course of employment
- If the diagnosis of the workers' compensation injury would affect the employer's premium
- Medical information that a treating medical provider deems is necessary for the employer to have in order to modify the employee's work duties.

Death Benefits

Section 5406.6 of the Labor Code relates to the statute of limitations for collecting workers' compensation benefits for the death of a health-care worker, public safety employee, or certain correctional peace officers from an HIV-related disease. These statutes state that a proceeding to collect benefits must commence within one year from the date of death, provided that certain events have occurred.

More information on [California's HIV/AIDS laws](#) is available on the California Division of Public Health website.

Impartiality

All evaluators—whether a QME, an AME, or a treating physician—are asked to provide medical opinions that are fair, impartial, and based on their best medical judgment. Specifically, evaluators are required to treat all injured workers in the same way—that is, not to discriminate against or be biased against anyone because of race, sex, national origin, religion, or sexual preference or because of whether the worker is represented by an attorney. Evaluators are also expected not to be biased in favor of the worker or in favor of the insurance carrier/employer. ***In fact, an evaluator must refuse any compensation, from any source, contingent upon writing a biased report 8 CCR 41(c)(1).***

If the WCAB finds that a treating physician's report is biased or deficient in other ways (opinions that are the result of conjecture or are not supported by adequate evidence), it will report this to the administrative director of the DWC. If any physician's reports show a pattern of bias or other unsupported opinions, the administrative director will report this to the appropriate licensing body (Labor Code § 4068).

Box 15-10. Workers' Compensation Truth in Advertising

The following disclosure must be made on all advertising that solicits people to file claims or to engage counsel or consult counsel or a medical-care provider or clinic to consider a workers' compensation claim:

NOTICE

Making a false or fraudulent workers' compensation claim is a felony subject to up to five years in prison or a fine of up to \$50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.

The statement must be printed in **boldface in at least 12-point type**.

Malpractice

In the case of *Mero v. Sadoff* (1995) 31 Cal.App. 4th 1466, 60 CCC 7, the Court of Appeal reversed a summary judgment against the plaintiff (thereby permitting trial on the issue), holding that an evaluating physician for a workers' compensation injury may be held liable for negligent acts committed during a workers' compensation defense examination. The court held that, even in the absence of a physician-patient relationship, the physician has a duty to the examinee to conduct the exam in a manner that does not harm them.

Fraudulent Workers' Compensation Claims

It is unlawful for a physician to do any of the following:

- Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation
- Present or cause to be presented any knowingly false or fraudulent written oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying compensation
- Knowingly assist, abet, conspire with, or solicit any person in an unlawful act under this section
- Make or cause to be made any knowingly false or fraudulent statements with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim. (Ins. Code § 1871.4)

"Statement," as used here, "includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, x-ray, test results, medical-legal expense as defined in section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment."

Providers who are approached by any individual or organization requesting that they participate in potentially fraudulent activity should report them to the Bureau of Fraudulent Claims, Department of Insurance, or their local district attorney.

Box 15-11. Unacceptable Advertising Copy

HURT ON THE JOB?

IF YOU'RE IN PAIN FROM
YOUR WORK INJURY
I CAN GET YOU
RESULTS
AND HELP WITH YOUR SETTLEMENT!
CALL 1-800-000-000
FOR AN APPOINTMENT TODAY

DR. WILL CHEATEM
DR. ANNE HOWE.

It is against the law to make a false workers' compensation claim. If the evaluator believes that a worker has been misled to believe that he or she should file a claim that is false, the provider may want to inform that worker about the penalties involved in making fraudulent claims. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison (Ins. Code §1871.2).

What Constitutes Appropriate Advertising for QMEs?

The DWC does not give legal advice on advertising, but it has issued regulations that address "advertising concerning medical services regarding industrial injuries or illnesses" (Labor Code § 139.4; 8 CCR §§ 150-159). "Advertising copy" includes any public communication under Business & Professions Code § 651. For example, listings in a medical directory or letterhead are both considered "public communications."

Generally, a QME may advertise:

- the name of the physicians affiliated with the physician's practice
- business hours
- area of practice in which the physician is engaged
- the physician's appointment as a QME by the DWC
- languages spoken fluently by the physician or the staff
- diagnostic services available
- whether services are performed on a lien basis
- biographical information
- scheduling time
- a statement that the physician is certified by a specialty board accredited by the American Board of Medical Specialties, the Medical Board of the State of California, the American Osteopathic Association, or the American Board of Professional Psychology. The name of the board granting the specialty status must be included in the ad. QMEs should not advertise (including on their letterhead) that they are certified in any specialties not recognized by one of these boards.

Impermissible advertising includes the following:

- anything that would create a false impression that favorable results could be achieved by using a particular physician
- any advertisement that implies a relationship between an individual physician or a private practice and the state of California
- use of the acronym IME or QME or the phrases “Qualified Medical Evaluator” or “Independent Medical Evaluator” within a firm name, trade name, or business name. For example, Dr. John Smith may not advertise as “Smith QME Exams, Inc.,” or “Dr. Smith’s Quickie QMEs,” but could advertise as “Dr. John Smith, Qualified Medical Evaluator.”

The administrative director may review advertising copy. Any QME who is found by the administrative director to have violated any provision of Labor Code § 139.4(c) may be terminated, suspended, or placed on probation. Physicians may send their advertising copy to the DWC for review, if there are questions about whether the copy complies with the regulations.

Conflicts of Interest

An evaluator may not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under Labor Code § 139.2(o). The administrative director of the DWC is responsible for developing regulations on conflict of interest (8 CCR § 41.5).

Chapter 16

Information for Office Staff

Key concepts:

- Paperwork Required for Medical-Legal Evaluations
- Procedures Before and During the Evaluation
- Mandatory Time Lines
- Reports That Must Be Written and When They Are Due

Introduction

The chapter is written for the office manager, billing personnel, and office staff. Because the workers' compensation system is complex, a physician's staff can help workers navigate the system.

The following discussion provides some basic guidelines on the paperwork required for medical-legal evaluations, the procedures before and during the evaluation, and information on the mandatory time lines. Treating physicians, whose office staff may be less familiar with the paperwork of this complex system, are also given guidelines on the reports they must write and when they are due.

Assisting the Injured Worker

The workers' compensation system is unfamiliar territory for most injured workers, who know very little about the process. Office staff personnel can help workers through the Qualified Medical Evaluator (QME) exam process by providing complete instructions, offering explanations, and avoiding the use of medical terminology that the workers may not understand. Workers should be treated with respect and be provided with the necessary assistance to complete the exam process effectively.

Staff at the Treating Physician's Office

Under California workers' compensation laws, treating physicians can have the added role of medical-legal evaluation of an injured worker's case. In particular, the treating physician's reports will be used to make critical decisions about whether a worker receives workers' compensation benefits, such as temporary and permanent disability payments, and future medical treatments. For this reason, timely delivery of the physician's reports is very important.

The Official Medical Fee Schedule (OMFS) should be used to bill for treatment **and for most reports**. In most cases, requests for authorization or services will undergo utilization review (UR) (see Chapter 9). When a request is made to perform an evaluation to address questions in a legal dispute, the Medical Legal Fee Schedule should be used. Both of these [fee schedules](#) are available on the DWC website.

How QME Panel Appointments Are Arranged

The QME process usually begins when either party disputes the treating physician's report. When this happens, the patient will select the specialty of the QME they will see. The patient may consult

with the treating physician as to the specialty prior to the selection, but the choice belongs to the patient. A key point to remember is that an injured worker is the treating physician's patient but does not have the same doctor/patient relationship with the selected QME.

In disputes over compensability, the unrepresented injured worker may select any QME from the QME panel made available to the worker by the DWC. For other disputes (over permanent disability or other medical issues), the unrepresented worker submits a completed [QME Form 105](#) to the DWC. On the form, the injured worker requests a medical specialty from which a QME physician can be chosen.

When the DWC receives a request for a QME, a computerized database is used to generate a randomly selected panel consisting of three doctors in the requested specialty, as close as possible to the injured worker's home.

The unrepresented injured worker makes the first contact with the evaluating physician. The injured worker selects a physician from the panel list and makes an appointment for an evaluation. The appointment should be made within 25-60 days after the date the patient first contacts the QME's office.

If appointments are made before 25 days, it may be difficult to obtain the medical records and other information the QME needs to conduct a complete evaluation. If the appointment cannot be made within 60 days, the injured worker may accept a later appointment or may request that the DWC remove that physician's name from the list and substitute another QME.

When an unrepresented employee makes an appointment, the staff must complete an employee notification form. This form has to be postmarked or faxed to the employee and the insurer within five working days from the date the appointment was made. The form includes:

- name, address, and phone number of the injured worker
- name, address, and phone number of the worker's employer
- name, address, and phone number of the claims administrator/carrier and the specific injured worker's claim number. It may also be helpful to get the name of the claims examiner.

One way to ensure receipt of all needed information is to have a staff person fill out the QME Appointment Notification Form ([QME Form 110](#)) while talking to the injured worker. If the worker does not have this information, a staff person can call the employer. Complete information is needed to inform all involved parties that an appointment has been made, to arrange for proper billing, and to ensure that reports go to the proper places. QMEs can be disciplined by the DWC Medical Unit for failing to send this form.

Sometimes an injured worker will make an appointment for a QME exam without telling the doctor's office that the appointment was made for that purpose. To avoid unnecessary confusion and wasted time, injured workers should be asked whether the scheduled appointment is for a QME exam.

The physician's office must complete and mail the QME Appointment Notification Form within five *working* days after scheduling a QME evaluation to:

- injured worker
- claims administrator/insurer.

This will allow parties to send medical records and other related information so that the physician can complete and submit the evaluation within the required 45-day (pre-1994 date of injury) or 30-day (post-1994 date of injury) timeframes.

Key Reminders

The following are the most common areas where a mistake or omission can occur in unrepresented cases:

- obtaining medical records
- completing the required forms/dealing with problem appointments
- serving report on the parties
- timeframes/extensions.

Obtaining Medical Records

The medical records should be sent by the employer/insurer as soon as the QME Appointment Notification Form is received. If the medical records are not received by the appointment date, the clinic may contact the employer/insurer solely to request the medical records. The clinic must not discuss any aspects of the case with the employer/insurer. The employer/insurer is also required to send medical records to unrepresented workers 20 days before this information is sent to the QME. The clinic may also call the treating physician to request records, with a signed release form from the patient.

Make Sure the Injured Worker Has Completed DEU Forms 100 and 101

Before any disability evaluation is done, an unrepresented injured worker should have received an Employee's Permanent Disability Questionnaire ([DWC-AD Form 100 DEU](#)). If the worker does not have this form, the worker should fill one out at the time of the appointment. It is advisable to keep a stack of Form 100s in the office in case the injured worker forgets to bring it to the examination. The QME should also receive a Request for Summary Rating Determination ([DEU Form 101](#)) from the employer/insurer. This request form contains the address of the Disability Evaluations Unit (DEU) office to which the completed medical evaluation must be sent. (The DEU is a unit within the DWC. DEU jurisdiction is based upon the injured worker's home zip code and can be determined by consulting the WCAB or the DWC office in your area.) The DEU will not complete a disability rating unless the two completed forms are submitted with the medical evaluation report. If either of the forms is missing, the DEU will send the incomplete package back to the QME.

The Total Package

A complete package of material to send to the local DEU office to rate a QME evaluation for unrepresented workers must include the following:

- the QME evaluation
- the Findings Summary Form ([QME form 111](#)) as a cover sheet
- DEU Forms 100 and 101
- Proof of Service (defined below).

In unrepresented cases, a QME's Findings Summary Form (QME Form 111) must accompany all copies of the report. The Findings Summary Form acts as a cover sheet to the report and must ac-

company each of the three reports sent out. This form summarizes the main points of the report. It must be filled out completely; do not leave any portions blank. The checklist included in this packet specifies the areas that must be covered in the report.

Serving the Report

Medical-legal evaluators must serve reports in a timely manner. To serve a report means that a form known as “[proof of service](#)” is attached to the back of the report, showing when and to which parties the document was mailed. It is signed by the person who mailed it, and a copy should be kept on file. The reports must not be sent directly from the evaluating physicians to the DWC or to the Workers’ Compensation Appeals Board (WCAB) as the parties are responsible for doing that.

One copy of the report must be sent out to each of the following parties:

Type of Case	Send Copy of Report to
AME	Both attorneys or claims administrator, if there is no defense attorney
Panel QME (unrepresented)	Injured worker (IW), claims administrator, local DEU office
Panel QME (represented)	Defense attorney, applicant’s attorney claims administrator

Timeframes for Serving QME Reports

For injuries that occurred prior to January 1, 1994, the physician must serve the report on the parties within 45 days of beginning the evaluation process. For injuries after January 1, 1994, this has been shortened to 30 days.

Time Extensions

The DWC can grant 30-day extensions to the 30-day time period when test results or a consulting physician’s report are not received by the evaluating physician in a timely manner or the physician has “good cause” for the delay. “Good cause” is defined generally as a family emergency or natural disaster that interferes with the physician’s normal office operations. When this occurs, a QME Timeframe Extension Request ([QME Form 112](#)) must be sent to the injured worker, the employer/insurer, and the executive medical director no later than 25 days after the date of the initial evaluation. Information provided should indicate the reason(s) why the report will be late and an estimated date when it will be completed and mailed. If the report will not be completed within an additional 30 days (60 days from the initial evaluation appointment), the executive medical director may deny the extension request or the injured worker may request that a new evaluation by a different doctor be performed. If either occurs, the original QME evaluation will be inadmissible, and the QME physician who performed the late evaluation will not be paid unless the employee waives his or her right to a new evaluation.

Box 16-1. Time Extensions

All requests for an extension of time to serve the medical-legal report (30 or 45 days) must be on a [QME Extension Request Form](#) and served on the executive medical director prior to granting the extension. Only valid reasons will support an extension. Late reports without valid extensions may be denied payment.

Billing and Independent Bill Review

The [Official Medical Fee Schedule](#) must be used to bill for treatment and for most reports. In most cases, any requests for authorization or services will undergo UR. At some point, if an evaluation is requested to address questions in a legal dispute, the [Medical Legal Fee Schedule should be used](#).

Independent Bill Review (IBR)

Medical treatment and medical-legal billing disputes are resolved through an independent bill review (IBR) process. A medical provider who disagrees with the amount paid by a claims administrator on a properly documented bill may apply for IBR. IBR applies to any medical service bill for which the date of service is on or after January 1, 2013, and where the fee is determined by a *fee schedule* established by the DWC.

A medical provider who disputes payment for medical service or medical-legal billing must submit a timely request to the claims administrator for a second review of the bill. Providers who disagree with the outcome of the second review may request IBR within 30 days after service of the second-review decision.

To request IBR, the medical provider must submit an application for IBR either electronically or on paper. An application for IBR can be completed and submitted electronically by registering as a user on the [Maximus Federal IBR tracking system](#).

If the request is made on paper, the following information should be included:

- completed application for independent bill review
- a check or money order for the IBR fee of \$250.00 (this fee may be reimbursed if the determination finds any amount of additional money is owed the provider)
- any required or supporting documentation

The request should be mailed to:

DWC-IBR
c/o Maximus Federal Services, Inc.
PO BOX 138006
Sacramento, CA 95813-8006

A medical provider can request that separate medical billing disputes be consolidated as part of IBR. Separate requests for IBR must be submitted as part of the initial IBR request and must meet criteria specified in the *IBR regulations*.

The request for consolidation must specify each dispute for which aggregation is being requested, along with a description of how the requests involve common issues of law and fact or delivery of similar or related services.

The explanation given by the provider must meet the following criteria:

- **Aggregation:** Two or more requests by a single provider may be aggregated if the administrative director (AD) or independent bill review organization (IBRO) determines that the requests involve common issues of law and fact or the delivery of similar or related services.
- **Consolidation for service dates:** Requests for IBR by a single provider involving multiple dates of medical treatment services may be consolidated into one request if the requests involve one employee, one claims administrator, and one billing code.

The total amount of the dispute cannot exceed \$4,000.

- **Consolidation for billing codes:** Requests for IBR by a single provider involving multiple billing codes may be consolidated into one request if the requests involve one employee, one claims administrator, and one date of medical treatment service.
- **Consolidation upon good cause showing:** Requests for IBR by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes may be consolidated into one request if there are multiple employees and multiple dates of service but one claims administrator and one billing code.

The IBRO may **disaggregate** a request into separate requests, and, in the event of disaggregation, the provider must pay the required fee for each request.

Upon receipt of [DWC form IBR-1](#), the administrative director (AD) or designee reviews the request to determine its eligibility for IBR.

If the AD determines that the request for IBR is not eligible, either party may appeal that determination by filing a petition with the WCAB.

Untimely requests, requests made prior to completion of a second review, and requests made without payment of the required fee are not eligible for IBR. A request may be ineligible for IBR until after resolution of a disputed issue, such as contested liability. If the AD determines that a request is not eligible for IBR, the provider will receive partial reimbursement of the fee paid with the request.

However, if the AD determines that a request for IBR is eligible, the AD will assign the request to an IBRO to conduct a review and issue a determination.

Upon referral by the AD, the IBRO notifies the parties of the assignment and provides them with an IBR case or identification number.

The IBRO assigns an independent bill reviewer to examine all documents submitted, apply the appropriate fee schedule (i.e., Official Medical Fee Schedule, Medical Legal Fee Schedule, Contract Reimbursement Rates per Labor Code 5307.11), and issue a written determination within 60 days of the assignment to IBR.

If the determination finds that any additional amount of money is owed to the provider, the determination shall also order the claims administrator to pay the additional sum owed and reimburse the provider for the filing fee.

The IBR determination is deemed the determination of the AD, and it is binding on all parties.

How to Withdraw an IBR Request

If a joint written request for withdrawal is made by the provider and claims administrator before a determination on the amount of payment owed is made, the request for IBR can be withdrawn.

If a request for IBR is withdrawn, the provider is not entitled to reimbursement of the required fee.

Can the IBR Determination Be Appealed?

Yes. Within 20 days of mailing the IBR determination, the provider or claims administrator may appeal by filing a verified petition with the WCAB.

IBR Resources and Forms

- Request for independent bill review form
- Provider's Request for Second Bill Review form
- Medical Billing and Payment Guide: February 2014
- Medical Billing and Payment Guide: January 2013
- Electronic Medical Billing and Payment Companion Guide: February 2014
- Electronic Medical Billing and Payment Companion Guide: January 2013
- Frequently asked questions about independent bill review
- IBR regulations
- IBR decisions

Glossary of Workers' Compensation Terms

The following are common terms that may be encountered during a workers' compensation claim. The definitions are general in nature and are not intended to serve as legal definitions.

A

AA or A/A: Applicant's attorney

Accepted claim: A claim in which the insurance company agrees that an employee's injury or illness is covered by workers' compensation. An employee should hear whether a claim is accepted or denied from the employer or its claims administrator within 90 days from the date the claim form was given to the employer. If an employee receives no notice, the injury will be presumed to be covered. An injured employee has the right to receive up to \$10,000 in medical care under treatment guidelines while the employer decides whether to accept or deny the employee's claim. The employer must approve that treatment within one working day of receiving the employee's claim form.

ACOEM: American College of Occupational and Environmental Medicine, an organization that has published medical treatment guidelines.

AD: Administrative director of the Division of Workers' Compensation.

ADA: See Americans with Disabilities Act

ADL: Activities of Daily Living.

Administrative Law Judge (WCALJ, ALJ, Judge): See *Workers' compensation administrative law judge*

Aggravation: If an individual has a non-industrial pre-existing condition that was made worse because of some exposure at work, the result is considered a new injury. The effects may be temporary or permanent. One of the terms used to describe such a situation is "aggravation."

Agreed medical evaluator (AME): If the injured worker has an attorney, an AME is the doctor the worker's attorney and the insurance company agree on to conduct the medical examination who will help resolve a dispute. If an employee doesn't have an attorney, the employee will use a qualified medical evaluator (QME). (See *QME*.)

Agreed QME: An evaluator chosen when an objection is made to an issued panel, and the parties agree in writing on the QME who will conduct the evaluation.

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

American Medical Association (AMA): A national physicians' group. The AMA publishes the "Guides to the Evaluation of Permanent Impairment." If an employee's permanent disability is rated

under the 2005 rating schedule, the doctor is required to determine an injured worker's level of impairment using the AMA Guides.

Americans with Disabilities Act (ADA): A federal law that prohibits discrimination against people with disabilities.

AOE: "Arising out of employment" means that an injury or illness was work related in whole or in part. It is a medical determination based on the information collected by a physician in obtaining a history related to the injury or illness.

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 the injured employee, who 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 an employee in his or her workers' compensation case. Applicant refers to the injured worker.

Application for adjudication of claim (application or app): A form an employee files to open a case at the local WCAB office if the employee has a disagreement with the insurance company about his or her claim.

Apportionment: A way of figuring out how much of an employee's permanent disability is due to his or her work injury and how much is due to other disabilities or causes.

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

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

Award: Award by WCAB, as in "Findings and Award," or F & A.

AWW or AWE: Average Weekly Wage, or Earnings.

B

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

Board: Workers' Compensation Appeals Board. The term is also used in reference to the local office of the WCAB where hearings are held.

Body part: This term refers to the part of the body that was injured and is at issue in a workers' compensation claim. The term "psyche" as a body part refers to psychological or psychiatric injury. More than one body part may be injured, and body parts may be added during the life of a claim of injury.

C

California Insurance Guarantee Association (CIGA): This agency pays the claims of insolvent property and casualty insurance carriers that are licensed to do business in the state.

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

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.

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: The form used to report a work injury or illness to the employer.

Claims adjuster: See *Claims administrator*.

Claims administrator (CA): The term for insurance companies and others that handle a 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*.

COE: Course of Employment. An injury, to be compensable, must arise during the course of employment. Course of employment is a legal determination concerning whether an illness was work related and is a determination by a workers' compensation judge that will be based on the evidence provided by the employer, the employee, and the physician. See also *AOE/COE*.

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 the employee's] permanent disability award.

Comp: Workers' compensation.

Compensable injury: Any injury arising out of employment (AOE) and occurring in the course of employment (COE). For a condition to be considered a compensable injury there must be physical or psychological harm to an individual who is employed, suffered while the individual was performing a service that was part of and was incidental to the individual's employment.

Compromise and release (C&R): A type of settlement in which an employee receives a lump sum payment and becomes responsible for paying for his or her future medical care. A settlement like this must be approved by a workers' compensation judge.

Continuing medical treatment: Occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

Cumulative injury/Cumulative trauma (CT): An injury that was caused by repeated events or repeated exposures at work.

D

Date of injury (DOI): The date when an employee was hurt or became ill. If the injury was caused by one event, the date it happened is the date of injury. If the injury or illness was caused by repeat-

ed exposures (a cumulative injury), the date of injury is the date the employee 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 to Proceed (DOR, DR, DRP): This is a form completed to request a hearing before an administrative law judge to resolve a dispute related to a workers' compensation claim.

Defendant: The party (usually the employer or its insurance company) opposing the employee in a dispute over benefits or services.

Defense counsel/Defense attorney (DA, DC, Def Atty): The attorney representing the employer or the insurance company in workers' compensation disputes.

Defense QME: An evaluator chosen by the defense when an applicant has not made a timely choice of one of the three QMEs listen on a panel that has been issued.

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

Delayed claim: This is a claim in which the employer or the insurance company investigates the circumstances of the claim to determine whether the claim is compensable prior to accepting or denying liability for the claim.

Demand: A proposal to settle made by the employee or the employee's attorney; a counter proposal by the defendant is called an **Offer**.

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

Department of Industrial Relations (DIR): A department of the State of California created in 1927. It is part of the California Labor and Workforce Development Agency and improves the conditions for California's workers and advances opportunities for employers. DIR has four divisions, six commissioners, boards, and programs.

Deposition (Depo): A deposition is testimony taken under oath, out of court, for later use in court.

Description of employee's job duties (RU-91): A form filled out jointly by the employee and the insurance company that helps the employee's treating physician decide whether the employee will be able to return to the injured worker's normal job and working conditions.

Determination and order (D&O): A decision by the DWC Rehabilitation Unit regarding a vocational rehabilitation dispute.

Disability: A physical or mental impairment that limits an employee's 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 the employee and the employee's treating doctor and the progress of the employee's medical treatment is reported to the insurance company.

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

Disability rating: See Permanent disability rating.

Discrimination claim (Labor Code 132a): A petition filed if the employer has fired or otherwise discriminated against an employee for filing a workers' compensation claim.

Dispute: A disagreement about the employee's right to payments, services or other benefits, or medical treatment services.

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.

Division of Occupational Health and Safety (DOSH, Cal/OSHA): A component of the Department of Industrial Relations that "protects workers and the public from safety hazards through its Occupational Safety and Health, elevator, amusement ride, aerial tramway, ski lift and pressure vessel inspection programs, and also provides consultative assistance to employers."

DWC 1: See Workers' Compensation Claim Form.

E

Electronic Adjudication Management System (EAMS): A computerized system to simplify and improve the DWC case management process. Please visit the DWC website for further information about the [EAMS system](#).

Emergency treatment: Health-care services for a medical condition that is so severe that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

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

Employer (ER): The person or entity with control over an employee's work activities.

Employment Development Department (EDD): A state agency that administers disability insurance and unemployment insurance benefits.

Employment 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.

Employee Retirement Income Security Act (ERISA): "The [Employee Retirement Income Security Act of 1974 \(ERISA\)](#) is A federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

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

Evidence-based medicine (EBM): A systemic method of making clinical decisions that involves applying the best available scientific evidence to recommend the most appropriate treatment for individual patients.

Ex parte communication: Generally a private communication with a judge, arbitrator, AME, or QME regarding a disputed matter without the other party being present or copied with correspondence. Ex parte communication is forbidden. A physician who performs a medical-legal evaluation of an injured worker is prohibited from ex parte communication with representatives of the injured worker or the employer. If a physician wishes to communicate with one party, the communication must be made to both parties simultaneously.

Exacerbation of a pre-existing condition: See *Recurrence of a pre-existing condition*.

F

Fair Employment and Housing Act (FEHA): A state law that prohibits discrimination against people with disabilities. An employee who believes he or she has been discriminated against at work because the individual is disabled and wants more information on an individual's rights under the FEHA can 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 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.

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 before the deadline is reached.

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

First aid: In the workers' compensation system, first aid refers to treatment provided by a physician or other licensed medical provider on a one-time basis, possibly with a single follow-up visit, for a minor condition that ordinarily would not require medical care. Treatment of an injury is not considered first aid if more than one visit is required for treatment or if the injured worker misses more time from work than the shift during which the injury occurred. An employer is not required to report an injury that requires only first aid. However, a physician who provides first-aid treatment must complete a doctor's first report of work injury.

Flare-up of a pre-existing condition: See *Recurrence of a pre-existing condition*.

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

Functional Capacity Evaluation (FCE): This is a formal assessment of an individual's physical capabilities. "A [functional capacity evaluation](#)" is set of tests, practices and observations that are combined to determine the ability of the evaluated individual to function in a variety of circumstances (most often work), in an objective manner."

Future Earning Capacity (FEC): A multiplier that increases the disability rating based on how much wage loss a type of injury causes on average compared to other types of injuries.

Future medical treatment: Treatment that is anticipated at some time in the future and is reasonably required to cure or relieve the employee of the effects of the injury. An award for future medical treatment can occur when the injured worker's condition is permanent and stationary.

G

Ghostwriting: As it relates to medical-legal reports, a medical report is ghostwritten if it is prepared in whole or in part by an individual or entity other than the physician who performed the actual evaluation. Ghostwriting is prohibited.

H

Health care organization (HCO): An organization certified by the DIR 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.

I

Impairment: The reduction or loss of function of an organ or body part compared to the prior level of function.

Impairment rating: A percentage estimate of how much normal use of the worker's injured body parts has been lost. Impairment ratings are determined based on guidelines published by the AMA. An impairment rating is used to calculate the injured worker's permanent disability rating. It is not the same as a permanent disability rating. .

In pro per: An injured worker not represented by an attorney and acting as his or her own attorney.

Independent contractor: There is no set definition of this term. Labor law enforcement agencies and the courts look at several factors when deciding whether someone is an employee or an independent contractor. Some employers misclassify employees as independent contractors to avoid workers' compensation and other payroll responsibilities. Just because an employer says an individual is an independent contractor and doesn't need to cover the individual under a workers' compensation policy doesn't make it true. A true independent contractor has control over how his or her work is done. An individual is probably not an independent contractor if the person paying that individual: Controls the details or manner of the individual's work, has the right to terminate the individual, pays the individual an hourly wage or salary, makes deductions for unemployment or Social Security, supplies materials or tools, or requires the individual to work specific days or hours.

Independent medical examiner (IME): For injuries occurring on and after January 1, 1991, whenever the term “independent medical examiner” is used, the term means “qualified medical examiner.”

Industrial Medical Council (IMC): No longer in existence. See *Medical Unit*.

Independent Medical Review (IMR): An employee who is covered by an MPN and who disputes his or her physician’s recommended tests or treatments may seek a second and third opinion from another MPN physician. If the test or treatment remains disputed after a third opinion, the employee may request IMR. Independent medical reviewers or independent medical review organizations are selected by the AD to perform reviews using the same standard as the medical treatment utilization schedule.

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.

Injured Worker: Another term for an injured employee or applicant.

Injury: A new injury or illness or a non-industrial pre-existing condition that was made worse because of some exposure at work, which is considered a new injury. One of the terms used to describe such a situation is “aggravation.” In the California workers’ compensation system, the term refers to an injury or disease occurring in the course of and arising out of employment, or resulting from treatment of an injury arising out of employment, or as a reaction to or side effect of preventative health care given to protect a health-care worker against occupational exposure to a disease.

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.

J

Judge (WCALJ, WCJ): See Workers’ compensation administrative law judge.

L

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 WCAB to request payment of money owed in a workers’ compensation case.

M

Mandatory settlement conference (MSC): A required conference to discuss settlement prior to a trial.

Maximum Medical Improvement (MMI): The injured worker’s condition is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Once an individual reaches MMI, a doctor can assess how much, if any, permanent disability resulted from the work injury.

Mediation conference: A voluntary conference held before an I&A officer to resolve a dispute if an employee is not represented by an attorney.

Medical care: See *Medical treatment*.

Medical determination: A decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

Medical-legal report: A report written by a doctor that describes an injured worker's medical condition. These reports are written to help clarify disputed medical issues.

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 AD 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 treatment utilization schedule (MTUS): Doctors in California's workers' compensation system are required to provide evidence-based medical treatment. That means doctors must choose treatments scientifically proven to cure or relieve work-related injuries and illnesses. Those treatments are laid out in the MTUS, which contains a set of guidelines with details on which treatments are effective for certain injuries, as well as how often the treatment should be given, the extent of the treatment, and for how long, among other things. (See also *Evidence-based medicine*.)

Medical Unit: A unit within the DWC that oversees MPNs, IMR physicians, HCOs, QMEs, panel QMEs, UR plans and UROs, spinal surgery second-opinion physicians, and the second-opinion process. Formerly called the Industrial Medical Council (IMC).

Modified work: An injured worker's old job, with some changes to accommodate the injured worker's abilities. If the injured worker's doctor says the injured worker will not be able to return to his or her job at the time of injury, the employer is encouraged to offer the employee modified work instead of supplemental job displacement benefits or vocational rehabilitation benefits.

N

Noncompensable injury: An injury that resulted from the use of alcohol or illicit drugs, was intentionally self-inflicted (including suicide), was due to an altercation in which the injured person physically initiated the altercation, or arose while the injured person was committing a felony for which the injured person was, or could be convicted, or related to off-duty recreational activity participation in which was not required as work related, or an injury claimed after the notice to the worker of termination or layoff.

Nontransferable voucher: A document an employee gets from the insurance company that must be completed by both the employee 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*.

O

Objective factors: Measurements, direct observations, and test results a treating physician, QME, or an AME says contribute to an employee's permanent disability.

Occupational disease: A disease caused in whole or in part by work.

Off calendar (OTOC): A WCAB case in which there is no pending action.

Offer of modified or alternative work (DWC form #AD 10133.53): A form the injured worker will get from the insurance company if: he or she was injured in 2004 or later and the injured worker's treating physician reports the worker has a permanent disability and the employer is offering modified or alternative work instead of a supplemental job displacement benefit. This form also explains how the injured worker's permanent disability payments may be lowered by 15% because the employer is returning the injured worker to work.

Offer of modified or alternative work form (RU-94): A form an injured worker will receive from the insurance company if he or she was injured before 2004 and the worker's treating physician says the worker probably will never return to his or her job or one like it and the employer is offering modified or alternative work instead of vocational rehabilitation benefits.

Official Medical Fee Schedule (OMFS): A fee schedule used for payment of medical services required to treat work related injuries and illnesses that is promulgated by the DWC AD.

Order Approving Compromise and Release (Order Approving C & R, OACR): An order issued by a workers' compensation administrative law judge that finalizes a settlement agreement.

OSHA: Occupational Health and Safety Act. See *Division of Occupational Health and Safety*.

P

P&S report: A medical report written by a treating physician that describes the employee's medical condition when it has stabilized. (See also *permanent and stationary*.)

Panel-qualified medical evaluator (QME/PQME): A panel-qualified medical evaluator will be on a list of three independent QMEs issued by the DWC Medical Unit. The injured employee may select any one of the three doctors for his or her evaluation. If the employee has an attorney, other rules apply.

Party: Normally this includes the insurance company, the employer, attorneys, and any other person with an interest in the injured employee's claim (doctors or hospitals that have not been paid).

Penalty: An amount of money the employee receives because something was not done correctly in his or her claim. Paid by the employer or the insurance company, the penalty amount can be an automatic 10% for a delay in one payment to the injured worker, or a 25% penalty—up to \$10,000—for an unreasonable delay.

Permanent and stationary status (P&S): The point at which the employee has reached maximum medical improvement. After an individual is P&S, a doctor can assess how much, if any, permanent disability resulted from the work injury. If the employee's disability is rated under the 2005 schedule, the term "maximum medical improvement" is 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 the injured worker is due in the future.

Permanent disability (PD) benefits: Payments the employee receives when his or her work injury permanently limits the kinds of work he or she can do or his or her ability to earn a living.

Permanent disability rating (PDR): A percentage that estimates how much a job injury permanently limits the kinds of work an individual can do. It is based on the individual's medical condition, date of injury, age when injured, occupation when injured, how much of the disability is caused by the job, and the employee's diminished future earning capacity. It determines the number of weeks the employee is 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 the employee's disability, depending on when the employee was injured.

Permanent disability payments: A mandatory biweekly payment based on the undisputed portion of permanent disability received before or after an award is issued.

Permanent partial disability (PPD): Disability that interferes with the injured employee's future earning capacity.

Permanent partial disability award: A final award of permanent partial disability made by a workers' compensation judge or the WCAB.

Permanent partial disability (PPD) benefits: Payments the employee receives when his or her work injury partially limits the kinds of work he or she can do or his or her ability to earn a living.

Permanent total disability (PTD): Disability considered to render an injured employee totally unable to have future earning capacity.

Permanent total disability (PTD) benefits: Payments the injured worker receives when he or she is considered permanently unable to earn a living.

Personal physician: A doctor licensed in California with an MD degree (medical doctor) or a DO degree (osteopath), who has treated an employee in the past and has the employee's medical records.

Petition for reconsideration (Recon): A legal process to appeal a decision issued by a workers' compensation judge. Heard by the WCAB Reconsideration Unit, a seven-member, judicial body appointed by the governor and confirmed by the state senate.

Physician: As used in the rules about workers' compensation in California, 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. For the purpose of utilization review, a reviewing physician—as defined above—may be licensed in any state or the District of Columbia; only the medical director of a UR organization must be licensed in California. (See also *Personal physician*.)

Predesignated physician: A physician who can treat an employee's work injury if the employee advised the employer in writing prior to the work injury or illness and certain conditions are met. (See also *Predesignation*.)

Predesignation: The process employees use to tell an employer that they want their personal physician to treat them for a work injury. Employees can predesignate a personal doctor of medi-

ciné (MD) or doctor of osteopathy (DO) if their employer offers group health coverage; the doctor has treated the employees in the past and has their medical records; prior to the injury the employees' doctor agreed to treat them for work injuries or illnesses, and prior to the injury the employees provided their employer with the following in writing: Notice that the employees wanted their personal doctor to treat them for a work-related injury or illness and The employees' personal doctor's name and business address.

Preponderance of evidence: Evidence that, when weighed against opposing evidence, is more convincing and a higher probability of truth.

Presumptive work-related injuries: The legislature has defined certain conditions as presumptively work-related injuries for workers in specific categories of employment such as peace officers or fire fighters.

Primary treating physician (PTP): The doctor with overall responsibility for treatment of an employee's work injury or illness. This physician writes medical reports that may affect the employee's benefits. Also called *Treating physician* or *Treating doctor*.

Proof of service: A form used to show that documents have been sent to specific parties.

Q

Qualified injured worker (QIW): Entitled to vocational rehabilitation benefits. This benefit applies only if an employee was injured before January 1, 2004.

Qualified medical evaluator (QME): An independent physician certified by the DWC Medical Unit to perform medical evaluations.

Qualified rehabilitation representative (QRR): A person trained and able to evaluate, counsel, and place disabled workers in new jobs. Also called *Rehabilitation counselor*.

R

Rating: See *Permanent disability rating*.

Reasonable medical probability: The standard a physician is expected to follow when rendering a medical opinion. It means that the physician believes, from superior evidence, that something is probable or more likely than not, that there is at least a 51% likelihood of certainty attached to the opinion.

Reconsideration (Recon): See *Petition for reconsideration*.

Reconsideration of a summary rating: A process used when an employee does not have an attorney and the employee thinks mistakes were made in his or her permanent disability rating.

Reconsideration Unit: See *Appeals board*.

Recurrence of a pre-existing condition: If an individual has a previous industrial injury or illness, not caused by the individual's current employment, which becomes symptomatic, but not because of the effects of current employment, it is considered a "recurrence," "flare-up," or "exacerbation" of the pre-existing condition. If the pre-existing condition is due to previous employment, the responsibility for compensation lies with the previous employer.

Regular work: An employee's 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 the employee lived at the time of his or her injury.

Rehabilitation consultant: A DWC employee who oversees vocational rehabilitation procedures, makes decisions about vocational rehabilitation benefits, and helps resolve disputes.

Rehabilitation counselor: See *Qualified rehabilitation representative*.

Rehabilitation Unit: A unit within DWC that resolves vocational rehabilitation disputes, approves potential settlements of vocational rehabilitation services, and reviews and approves vocational rehabilitation plans for injuries that occurred before January 1, 2004.

Released from care: A determination by the PTP that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

Represented employee: An injured employee who is represented by an attorney.

Restrictions: See *Work restrictions*.

S

Schedule for rating permanent disabilities: See *Permanent disability rating schedule*.

Self-procured: Medical treatment of an employee that is not authorized by the employer.

Settlement: An agreement between the injured worker and the insurance company about his or her workers' compensation payments and future medical care. Settlements must be reviewed by a workers' compensation judge to make sure they are adequate.

Serious and willful misconduct: A petition filed if the employee's injury is caused by the serious and willful misconduct of the employer.

Social Security disability benefits: Long-term financial assistance for those who are totally disabled. These benefits come from the U.S. Social Security Administration. They are reduced by workers' compensation payments an injured worker receive.

Social Security Administration (SSA): The federal agency overseeing federal retirement benefits, and payments for disability and poverty under federal laws.

Social Security Disability (SSD): This refers to benefits consisting of long-term financial assistance for totally disable individuals. They are reduced by workers' compensation payments received.

Social Security Disability Indemnity (SSDI): See *Social Security Disability*.

Specific injury: An injury caused by one event at work, such as employee who has a back injury from a fall, is burned by a chemical splashed on the employee's skin, gets 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.

Stipulated rating: Formal agreement on the injured worker's permanent disability rating that must be approved by a workers' compensation judge.

Stipulation with award (Stip): A settlement of a case in which 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.

Striking process: If an injured employee is represented, the defense attorney and the employee's attorney each may object to, or strike, one of the three doctors on a panel. If both sides strike separate doctors, then the remaining one will perform the evaluation. If only one doctor is stricken (for whatever reason), the injured employee may select one of the two remaining doctors.

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.

Supplemental Security Income (SSI): Social Security benefits payable to those who are disabled or poor.

Summary rating: The percentage of permanent disability calculated by the DWC DEU.

Summary rating reconsideration: A procedure used if the employee objects to the summary rating issued by the DWC DEU.

Supplemental job displacement benefit (SJDB): A workers' compensation benefit. If an employee was injured in 2004 or later and has a permanent partial disability that prevents him or her from doing his or her old job, and the employer does not offer other work, the employee qualifies for this benefit. It 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. Also called a *Voucher*.

T

Temporary disability (TD or TTD): Payments the injured worker gets if he or she loses wages because his or her injury prevents him or her from doing his or her usual job while recovering.

Temporary partial disability (TPD) benefits: Payments the injured worker gets if he or she can do some work while recovering, but the employee can earn less than before the injury.

Temporary total disability (TTD) benefits: Payments the employee receives if he or she cannot work at all while recovering.

Transportation expenses: A benefit, usually a reimbursement, to cover the employee's out-of-pocket expenses for mileage, parking and toll fees related to a claim.

Treating doctor: See *Primary treating physician*.

Treating physician: See *Primary treating physician*.

U

Uninsured Employers Fund (UEF): A fund, run by the DWC, through which an employee's benefits can be paid if his or her employer is illegally uninsured for workers' compensation.

Unrepresented employee: An injured worker who is not represented by an attorney.

Utilization review (UR): The process used by insurance companies to decide whether to authorize treatment recommended by the injured worker's treating physician or another doctor.

V

Vocational rehabilitation (VR): A workers' compensation benefit. If an employee was injured before 2004 and is permanently unable to do his or her usual job, and the employer does not offer other work, the employee qualifies for this benefit. It includes job placement counseling to help the employee find another job. It may also include retraining and a vocational rehabilitation maintenance allowance.

Voucher: See *Nontransferable voucher* and *Supplemental job displacement benefit*.

W

Wage loss (temporary partial disability): See *Temporary partial disability benefits*.

Workers' compensation administrative law judge: A DWC employee who makes decisions about workers' compensation disputes and approves settlements. Judges hold hearings at local WCAB offices, and their decisions may be reviewed and reconsidered by the Reconsideration Unit of the WCAB. Also called a *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 state senate that hears appeals of decisions issued by local workers' compensation judges.

Workers' Compensation Claim Form (DWC 1): The [form used by an injured employee](#) to file a claim for benefits related to a work injury or illness. It is accompanied by an explanation of benefits and how an employee can file a claim.

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*.

Work restrictions: A doctor's description of the work the employee can and cannot do. Work restrictions help protect the employee from further injury.