

**Supplemental Job Displacement Benefit -Voucher Public Meeting – October 2, 2012**  
**Division of Workers’ Compensation**

Excerpts of Senate Bill 863

Labor Code section 4658.5:

- (a) This section shall apply to injuries occurring on or after January 1, 2004, and before January 1, 2013.
- (b) Except as provided in Section 4658.6, if the injury causes permanent partial disability and the injured employee does not return to work for the employer within 60 days of the termination of temporary disability, the injured employee shall be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state-approved or accredited schools, as follows:
  - (1) Up to four thousand dollars (\$4,000) for permanent partial disability awards of less than 15 percent.
  - (2) Up to six thousand dollars (\$6,000) for permanent partial disability awards between 15 and 25 percent.
  - (3) Up to eight thousand dollars (\$8,000) for permanent partial disability awards between 26 and 49 percent.
  - (4) Up to ten thousand dollars (\$10,000) for permanent partial disability awards between 50 and 99 percent.
- (c) The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. No more than 10 percent of the voucher moneys may be used for vocational or return-to-work counseling. The administrative director shall adopt regulations governing the form of payment, direct reimbursement to the injured employee upon presentation to the employer of appropriate documentation and receipts, and other matters necessary to the proper administration of the supplemental job displacement benefit.
- (d) A voucher issued on or after January 1, 2013, shall expire two years after the date the voucher is furnished to the employee or five years after the date of injury, whichever is later. The employee shall not be entitled to payment or reimbursement of any expenses that have not been incurred and submitted with appropriate documentation to the employer prior to the expiration date.
- (e) An employer shall not be liable for compensation for injuries incurred by the employee while utilizing the voucher.

Labor Code section 4658.6:

The employer shall not be liable for the supplemental job displacement benefit pursuant to Section 4658.5 if the employer meets either of the following conditions:

- (a) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, modified work, accommodating the employee’s work restrictions, lasting at least 12 months.
- (b) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, alternative work meeting all of the following conditions:
  - (1) The employee has the ability to perform the essential functions of the job provided.
  - (2) The job provided is in a regular position lasting at least 12 months.
  - (3) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(4) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

#### Labor Code section 4658.7:

(a) This section shall apply to injuries occurring on or after January 1, 2013.

(b) If the injury causes permanent partial disability, the injured employee shall be entitled to a supplemental job displacement benefit as provided in this section unless the employer makes an offer of regular, modified, or alternative work, as defined in Section 4658.1, that meets both of the following criteria:

(1) The offer is made no later than 60 days after receipt by the claims administrator of the first report received from either the primary treating physician, an agreed medical evaluator, or a qualified medical evaluator, in the form created by the administrative director pursuant to subdivision (h), finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability.

(A) If the employer or claims administrator has provided the physician with a job description of the employee's regular work, proposed modified work, or proposed alternative work, the physician shall evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description.

(B) The claims administrator shall forward the form to the employer for the purpose of fully informing the employer of work capacities and activity restrictions resulting from the injury that are relevant to potential regular, modified, or alternative work.

(2) The offer is for regular work, modified work, or alternative work lasting at least 12 months.

(c) The supplemental job displacement benefit shall be offered to the employee within 20 days after the expiration of the time for making an offer of regular, modified, or alternative work pursuant to paragraph (1) of subdivision (b).

(d) The supplemental job displacement benefit shall be in the form of a voucher redeemable as provided in this section up to an aggregate of six thousand dollars (\$6,000).

(e) The voucher may be applied to any of the following expenses at the choice of the injured employee:

(1) Payment for education-related retraining or skill enhancement, or both, at a California public school or with a provider that is certified and on the state's Eligible Training Provider List (EPTL), as authorized by the federal Workforce Investment Act (P.L. 105-220), including payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement.

(2) Payment for occupational licensing or professional certification fees, related examination fees, and examination preparation course fees.

(3) Payment for the services of licensed placement agencies, vocational or return-to-work counseling, and résumé preparation, all up to a combined limit of 10 percent of the amount of the voucher.

(4) Purchase of tools required by a training or educational program in which the employee is enrolled.

(5) Purchase of computer equipment, up to one thousand dollars (\$1,000).

(6) Up to five hundred dollars (\$500) as a miscellaneous expense reimbursement or advance, payable upon request and without need for itemized documentation or accounting. The employee shall not be entitled to any other voucher payment for transportation, travel expenses, telephone or Internet access, clothing or uniforms, or incidental expenses.

(f) The voucher shall expire two years after the date the voucher is furnished to the employee, or five years after the date of injury, whichever is later. The employee shall not be entitled to payment or reimbursement of any expenses

that have not been incurred and submitted with appropriate documentation to the employer prior to the expiration date.

(g) Settlement or commutation of a claim for the supplemental job displacement benefit shall not be permitted under Chapter 2 (commencing with Section 5000) or Chapter 3 (commencing with Section 5100) of Part 3.

(h) The administrative director shall adopt regulations for the administration of this section, including, but not limited to, both of the following:

(1) The time, manner, and content of notices of rights under this section.

(2) The form of a mandatory attachment to a medical report to be forwarded to the employer pursuant to paragraph (1) of subdivision (b) for the purpose of fully informing the employer of work capacities and of activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work.

(i) An employer shall not be liable for compensation for injuries incurred by the employee while utilizing the voucher.

## Issues for Discussion

- Forms:
  - Physician form: The claims administrator must provide the physician with a job description of the employee's regular work, proposed modified work, proposed alternative work so that the physician can evaluate and describe in the form whether work capacities and activity restrictions resulting from the injury are compatible with the physical requirements set forth in the job description. What information/data fields should be included in the form? Should the form include the job description or should that be provided on a document completed by the employer? Should the old RU-91 job description form (attached) be utilized? Should the Physician form be a mandatory attachment to a medical report to be forwarded to the claims administrator? At what point should the form be provided by the claims administrator to the physician? Should the functional capacity evaluation in Form PR-4 be eliminated? Should the form list restrictions narrowly tailored to the job or be more generic functional restrictions? Should the Physician form be modeled after the old RU-90 Treating Physician's Report of Disability Status form (attached)?
  - Offer of work: An employee is not entitled to the voucher if the employer makes an offer of regular, modified, or alternative work no later than 60 days after receipt of a mandatory work restriction form finding that disability from all conditions are P & S and the injury has caused PD. Should there be a regulations requiring a specific manner to evidence receipt (proof of service)? What changes should be made to the existing notice of offer of regular, modified or alternative work?
  - Voucher: What information should be included on the voucher itself? Should it have a proof of service?
- Regulations:
  - What new definitions are needed?
  - Should the division list counselors on its web page?

## DESCRIPTION OF EMPLOYEE'S JOB DUTIES

**INSTRUCTIONS:** This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job. If the employee needs help in completing this form, the employee may contact the Information and Assistance Officer at the Division of Workers' Compensation. The phone number can be found in the State Government section of the phone book.

EMPLOYEE NAME:	(LAST)	(FIRST)	(M.I.)	CLAIM#:
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EMPLOYER NAME:	JOB ADDRESS:
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JOB TITLE:	HRS. WORKED PER DAY:	HRS. WORKED PER WEEK:
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DESCRIPTION OF JOB RESPONSIBILITIES: (DESCRIBE ALL JOB DUTIES)

  
  
  
  
  
  
  
  
  
  

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3 - 6 hours	CONSTANTLY 6 - 8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Hand Use: Dominant hand Right--- Left---				
Is repetitive use of hand required?				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				

Fine Manipulation (left hand)				
Pushing & Pulling (right hand)				
Pushing & Pulling (left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried .

	LIFTING				Height	CARRYING				Distance
	Never 0 hrs	Occasionally up to 3 hrs	Frequently 3-6 hrs.	Constantly 6-8+ hrs.		Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	
0-10 lbs.										
11-25 lbs.										
26-50 lbs.										
51-75 lbs.										
76-100lbs.										
100+ lbs.										

Describe the heaviest item required to carry and the distance to be carried: \_\_\_\_\_

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?			_____
b. Working around equipment and machinery?			_____
c. Walking on uneven ground?			_____
d. Exposure to excessive noise?			_____
e. Exposure to extremes in temperature, humidity or wetness?			_____
f. Exposure to dust, gas, fumes, or chemicals?			_____
g. Working at heights?			_____
h. Operation of foot controls or repetitive foot movement?			_____
i. Use of special visual or auditory protective equipment?			_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.			_____

Employee Comments:

Employer Comments:

EMPLOYER CONTACT NAME:	EMPLOYER CONTACT TITLE:
EMPLOYER REPRESENTATIVE SIGNATURE:	DATE:
EMPLOYEE'S SIGNATURE:	DATE:
QUALIFIED REHAB. REPRESENTATIVE SIGNATURE: (IF APPLICABLE)	DATE:

**Rehabilitation Unit  
California Division of Workers' Compensation**

**Form RU-90**

**TREATING PHYSICIAN'S REPORT OF DISABILITY STATUS**

**Purpose:**

To allow early identification of employee's potential need for vocational rehabilitation services, the claims administrator or Qualified Rehabilitation Representative must solicit the treating physician's opinion concerning the employee's ability to return to previous employment.

**Submitted by:**

Qualified Rehabilitation Representative assigned by claims administrator, if the injury is before 1/1/94 or claims administrator if the injury is on or after 1/1/94.

**When submitted:**

At 90 days of aggregate temporary disability and thereafter at 60 day intervals, or less, until medical eligibility has been determined.

**Where submitted:**

To the treating physician. **Do not file the RU-90 or RU-91 with the Rehabilitation Unit unless specifically requested or when submitting information as part of a dispute.**

**Form completion:**

The Qualified Rehabilitation Representative or claims administrator completes the identification data on the form and the treating physician is responsible for the completion of the remainder of the form, including signature. **Be sure to fill in the claims administrator name and address or the doctor may become confused and return the form to the Rehabilitation Unit.** Upon completion, the treating physician returns the form to the claims administrator with a copy to the Qualified Rehabilitation Representative, if applicable, and injured worker.

**Accompanying document:**

Description of Employee's Job Duties (RU-91) must be included when the RU-90 is initially sent to the treating physician.

**Response to RU-90:**

The claims administrator within 10 days of receipt of the final Treating Physician's Report Of Disability Status (RU-90), shall notify the employee of his/her status using the prescribed Notice of Potential Eligibility or Denial of Vocational Rehabilitation Services, whichever is applicable.

The completed RU-90 is a medical report and is to be served on all parties by the claims administrator with the previously completed RU-91.

**Rehabilitation Unit action:**

None.

# TREATING PHYSICIAN'S REPORT OF DISABILITY STATUS

**INSTRUCTIONS:** Pursuant to requirements of the California Labor Code, please complete this form and return it to the claims administrator listed below within 15 days of receipt with a copy to the Qualified Rehabilitation Representative.

EMPLOYEE NAME:	(LAST)	(FIRST)	(M.I.)	SS#	DATE OF INJURY
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EMPLOYER NAME:

Attached is a description of the employee's job duties. Based on your examination, including the history provided by the patient and the enclosed job description, choose one of the following:

\_\_\_\_\_ I expect to release the employee to return to the pre-injury occupation on or about \_\_\_\_\_.

\_\_\_\_\_ The employee's permanent disability as a result of the injury whether or not combined with the effects of a prior injury or disability, if any is likely to preclude the employee from returning to work at the pre-injury occupation.

Is the employee currently physically able to participate in vocational rehabilitation services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe any physical limitations: \_\_\_\_\_

If employee is not physically able to participate in vocational services, please estimate when participation may be possible.

\_\_\_\_\_ At this time, I am unable to give an opinion concerning the employee's ability to return to the pre-injury occupation.

I expect to be able to provide an opinion on or about: \_\_\_\_\_

Please advise also if the employee is currently physically able to perform light duties if modified or alternative work is available:

\_\_\_\_\_ Yes, with the following limitations: \_\_\_\_\_

\_\_\_\_\_ No

Physician's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Please return to: Employer/Insurer/Adjusting Agent

Address: \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Send a copy to Qualified Rehabilitation Representative:

Address: \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)