

§ 9812 – Benefit Payment and Notice

Comment

Most claims administrators issue benefit notices and checks from separate locations. Simultaneous delivery would require expensive changes to their systems and processes.

Recommendation

§ 9812(c) “Notice of Changed Benefit Rate, Payment Amount or Schedule (TD, PD)... Notice shall be given before or ~~with the~~ at the time of new payment.”

§ 9812(d) “Notice that Benefits Are Ending (TD, PD). ~~With~~ Within five working days of the last payment of temporary disability indemnity or permanent disability indemnity,... ”

§ 9812(e)(1) “Condition Not Permanent and Stationary, May Cause Permanent Disability – Notice of Monitoring Until P&S Date. If the injury has resulted or may result in permanent disability, but the employee’s medical condition is not permanent and stationary, the claims administrator shall advise the employee ~~together with~~ within five working days of the last payment of temporary disability indemnity,..”

§ 9812(e)(2) “Notice That Permanent Disability Exists. ~~Together with~~ Within five working days of the last payment of temporary disability or within 14 days of knowledge...”

§ 9812(e)(3) “Notice That No Permanent Disability Exists... This notice shall be sent ~~together with~~ within five working days of the last payment of temporary disability or within 14 days after...”

§ 9812(e)(4) “Notice of Permanent Disability Indemnity Payment. ~~Together with~~ Within five working days of the first payment of permanent disability indemnity,... ”

§ 9812(f)(2) “Notice of Changed Benefit Rate, Amount or Schedule or that Benefits are Ending... A notice that payment is ending shall be sent ~~with~~ within five working days of the last payment unless the decision to end payment...”

§ 9812 – Description of the panel QME process; Request for DEU Rating of Treating Physician’s Report

Comment

Several benefit notices are required to include a description of the panel QME process. The required language varies depending on the specifics of the claim (i.e. if the claims’ administrator’s determination is based on a treating physician or a comprehensive medical

evaluation, if the employee has already received a comprehensive medical evaluation, if either party disagrees with the basis for determination). The Labor Code also allows either party in an unrepresented claim to request a DEU rating of the treating physician's permanent disability findings, in addition to the QME process. Thus, subdivisions 9812(e)(2) and (3), which address language regarding the request for the DEU rating, should be re-written to allow user to include that language in addition to – rather than instead of – the QME language. To promote consistency in language, the following recommendations for change are being submitted.

Recommendation

§ 9812(a)(3)(A)(2)

~~“ 2. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation. ”~~

§ 9812(a)(3)(A)(3)

~~“ 3. If the denial is based on the treating physician's evaluation of the employee's temporary disability status and the claims administrator agrees with the treating physician's evaluation of the employee's temporary disability status those findings, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must contact the claims administrator within the applicable time limit prescribed in Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. However, if the employee has already received a previous comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible. ”~~

§ 9812(a)(3)(A)(4)

~~“ 4. If denial is based on the treating physician's evaluation of the employee's temporary disability status and the claims administrator disagrees with the treating physician's evaluation of the employee's temporary disability status those findings, the notice shall advise the employee that the claims administrator disputes the results of the evaluation. If the claims administrator's determination is based on a medical report, the notice shall be provided within the applicable time limit prescribed in Labor Code section 4062(a), notwithstanding the 14 days required by this subdivision. The notice shall advise the employee that the claims administrator disputes the results of the evaluation and shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. When providing the form to request a panel of Qualified Medical Evaluators, the notice shall include the following statement: “Enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three qualified medical evaluators (QMEs). If you do not submit the form within **10 days**, we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must select a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform me of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform me of your choice, we will choose the QME who will examine you and we will arrange the appointment.” However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the~~

employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.”

§ 9812(d)(1)(B)

“ (B) If the termination of benefits is based on the treating physician’s evaluation of the employee’s temporary or permanent disability status and the claims administrator agrees with the treating physician’s evaluation of the employee’s temporary or permanent disability status those findings, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must contact the claims administrator within the applicable time limit prescribed in Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. However, if the employee has already received a previous comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible. ”

§ 9812(d)(1)(C)

“ 4. If termination of benefits is based on the treating physician’s evaluation of the employee’s temporary or permanent disability status and the claims administrator disagrees with the treating physician’s evaluation of the employee’s temporary or permanent disability status those findings, the notice shall advise the employee that the claims administrator disputes the results of the evaluation. If the claims administrator’s determination is based on a medical report, the notice shall be provided within the applicable time limit prescribed in Labor Code section 4062(a) and, notwithstanding the 14 days required by this subdivision. The notice shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. When providing the form to request a panel of Qualified Medical Evaluators, the notice shall include the following statement: “Enclosed is a form that you must submit to the state Division of Workers’ Compensation (DWC) within **10 days** to request a panel of three qualified medical evaluators (QMEs). If you do not submit the form within **10 days**, we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must select a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform me of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform me of your choice, we will choose the QME who will examine you and we will arrange the appointment.” However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible. ”

§ 9812(d)(2)

“ (2) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions. ”

§ 9812(e)(2)(A)(1) through (3)

“ (A) Where the employee is not represented by an attorney, ~~the notice shall advise the employee one of the following:~~

“1. If the claims administrator’s determination is based on an evaluation by a treating physician ~~and the employee is not represented by an attorney~~, the notice shall inform the employee whether or not the claims administrator is...

“ 2. If the claims administrator’s determination is based on an evaluation by a treating physician, the notice shall advise the employee one of the following:

“ [i] If the claims administrator agrees with the treating physician’s evaluation of the employee’s permanent disability status, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must contact the claims administrator to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. However, if the employee has already received a ~~previous~~ comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

“ ~~3-~~[ii] If the claims administrator disagrees with the treating physician’s evaluation of the employee’s permanent disability status, the notice shall advise the employee that the claims administrator disputes the results of the evaluation. The notice shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. However, if the employee received a previous comprehensive medical evaluation, the notice may instruct the employee on how to return to that same medical evaluator for a new evaluation if possible. When providing the form to request a panel of Qualified Medical Evaluators, the notice shall include the following statement: “Enclosed is a form that you must submit to the state Division of Workers’ Compensation (DWC) within **10 days** to request a panel of three qualified medical evaluators (QMEs). If you do not submit the form within **10 days**, we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must select a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform me of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform me of your choice, we will choose the QME who will examine you and we will arrange the appointment.” However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible. ”

§ 9812(e)(3)(A)(2) through (4)

“ 2. If the claims administrator’s determination is based on an evaluation by a treating physician ~~and the employee is not represented by an attorney~~, the notice shall inform the employee whether or not the claims administrator is requesting a rating from the Disability Evaluation Unit. If the claims administrator is not requesting a rating from the Disability Evaluation Unit, the notice shall advise the employee that he or she may contact an Information and Assistance office to have the treating physician’s evaluation reviewed and rated by the Disability Evaluation Unit. The notice shall also advise the employee of one of the following:

“ 3[i]. If the claims administrator agrees with the treating physician’s evaluation of the employee’s permanent disability status, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must contact the claims administrator to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. However, if the employee has already received a ~~previous~~ comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

“ 4[ii]. If the claims administrator disagrees with the treating physician’s evaluation of the employee’s permanent disability status, the notice shall advise the employee that the claims administrator disputes the results of the evaluation. The notice shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. ~~However, if the employee received a previous comprehensive medical evaluation, the notice may instruct the employee on how to return to that same medical evaluator for a new evaluation if possible.~~ When providing the form to request a panel of Qualified Medical Evaluators, the notice shall include the following statement: “Enclosed is a form that you must submit to the state Division of Workers’ Compensation (DWC) within **10 days** to request a panel of three qualified medical evaluators (QMEs). If you do not submit the form within **10 days**, we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must select a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform me of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform me of your choice, we will choose the QME who will examine you and we will arrange the appointment.” However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible. ”

§ 9812(e)(2) – Permanent Disability Notices

Comment

The first sentence in subdivision (e)(2) references to a “section 4650”, but does not indicate the source of said section.

Recommendation

~~“...Together with~~ Within five working days of the last payment of temporary disability or within 14 days of knowledge that the injury has caused permanent disability, whichever is later, the claims administrator shall inform the employee of the claims administrator’s estimate of the amount of permanent disability indemnity payable, the basis for the estimate, whether there will be the need for future medical care, and whether an indemnity payment will be deferred pursuant to paragraph (2) of subdivision (b) of Labor Code section 4650. ... ”

§ 9812(g)(1) – Notice Denying Liability for All Compensation Benefits

Comment

The proposed statement to be included in the notice, which states in part, “If you disagree with the enclosed medical report...”, would be incorrect where the basis for denial is a psychiatric report which the psychiatrist recommended not to be provided to the employee.

Recommendation

“ ‘If you disagree with the ~~enclosed medical report~~ decision to deny your claim and wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the...’ ”

Section 9881.1 – Notice to Employees Poster

Comment

The proposed language in the “Benefits can include” section lacks the more comprehensive and thereby more understandable description of each type of benefit an injured employee can expect to receive.

Additionally, the proposed language in the “If You Get Hurt” section has been over-simplified. The instruction to report the injury and file a claim form removes the language that explains what happens after the claim form is filed, including employee’s right to receive medical treatment up to \$10,000 until the claim is accepted or rejected.

Moreover, section 9881 requires that the Notice to Employees poster must include Medical Provider Network (MPN) information, if applicable, including MPN name, contact person, address, etc. It must also include information about the rights of the employee to select and change treating physician pursuant to Labor Code 4600. Although the proposed language provides information about pre-designation of treating physician, it does not include language about MPN or the employee’s right to change treating physician after 30 days of reporting injury. Instead, the proposed poster simply states, “For instructions, see the written information about workers’ compensation that your employer must give to all new employees.”

Recommendation

Retain the current version of the “Notice to Employees” poster, since it continues to meet the regulatory requirements, while offering a clearer and more understandable language than the proposed changes in describing the injured employee’s rights and duties.

Section 10139 – Workers’ Compensation Claim Form (DWC1) and Notice of Potential Eligibility

Comment

On top of page 3 of the Notice of Potential Eligibility, under the “PROBLEMS WITH MEDICAL CARE AND MEDICAL REPORTS” heading from page 2, a statement in part says, “If you have an attorney, the claims administrator must try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME).” Under SB863, the opposing parties in a represented claim are still allowed to utilize an AME, but are no longer required to attempt agreement on one.

Recommendation

“ If you have an attorney, the claims administrator ~~must~~ may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). ”

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Introduction

We appreciate the extraordinary efforts made by the Division to create the regulatory procedures necessary to revise the benefit notices in accordance with the new statutory reforms. The changes made by the Division following the Forum comments were very constructive. Eliminating the fact sheets and enclosures will streamline the workflow and reduce the cost of providing these notices for claims administrators. Enhancing the information available on the DWC's website will also make the notices less confusing for injured workers and provide access to more extensive information for those who need it.

We support the revisions drafted for the claim form with the recommended amendments, but oppose the draft versions of the Employee Poster and the Notice of Potential Eligibility (NOPE).

The Institute recommends that the Division allow 90 days from the date of adoption to the implement revisions to the benefit notice regulations, the Employee Poster, Claim Form and Notice of Potential Eligibility to allow sufficient time for programming, training, publishing, distribution, and posting.

Benefit Notices

Section 9810 -- General Provisions

Recommendation

(c) All notice letters shall identify the claims administrator's name, mailing address, telephone number and website address (if available), the employee's name, employer's name, the claim number, the date the notice was sent to the employee, and the date of injury. ...

Discussion

Many claims administrators, TPAs, and self-administered employers do not have website access available to the public. Smaller claims administrators use internal systems for processing and claims administration. Larger organizations will often have very specific security systems in place to protect the sensitive information they receive and their business processes. Therefore, providing the website address should be optional when that avenue of communication is feasible and mutually beneficial.

Section 9810 -- General Provisions

Recommendation

(b) The Administrative Director may issue and revise from time to time a Benefit Notice Instruction Manual as a guide for completing and serving the notices required by this Article. Benefit notices using the model language contained in the Benefit Notice Instruction Manual are presumed to be adequate notice to the employee and shall not be subject to audit penalties.

(c) Benefit notices, except those notices where language or format is set forth in statute or specific notice forms adopted by regulation, may be produced in any format developed by the claims administrator. Each such benefit notice shall contain all relevant notice elements required by either statute or regulation. The Administrative Director may make sample notices that comply with these requirements available on the DWC website. Benefit notices using the sample notices devised by the Administrative Director and available on the Division's website are presumed to be adequate notice to the employee and shall not be subject to audit penalties.

Discussion – Safe Harbor

Institute members have generally preferred to use the recommended language provided by the Division, such as that contained in the Benefit Notice Instruction Manual and the AD's sample notices, to fashion notices in any format that best suits their communications needs and the requirements of their systems. What has been lacking is an assurance that when these resources are used correctly, the claims administrator will be protected from penalties. The regulatory scheme must state clearly that if the claims administrator follows the DWC's procedures, sample forms, or the Benefit Notice Instruction Manual, then the Audit Unit and the WCALJs will accept that as a complete and proper notice.

In regard to benefit notices, Labor Code section 138.4 requires the Administrative Director to provide notices in clear, "plain language" to accomplish the statutory communication goals. The statute requires additional informational material to be available on the Division's website with instructions as to how to access this material. When the DWC has produced this material, it should suffice for both the audits and judicial scrutiny. The statutory authority cited by the Division in this regulation establishes the Division's right and obligation to ensure that injured workers received adequate and comprehensible information regarding their benefits. The Division has the authority to create clear benefit notices, and when it publishes sample forms and an instruction manual, the Division should guarantee that their proper use will not later be penalized or disregarded by WCALJs.

DWC Website

In several proposed regulations, the Division requires the claims administrator to refer the injured worker to the I&A Office and/or the DWC website for additional information. On multiple occasions, the Division has revised notice information on its website without notifying the community of the changes. For example, on March 27 of this year the Division issued Newsline 19-13 announcing it had revised the Fact Sheets -- including the mandatory enclosures on TD (Fact Sheet C), PD (Fact Sheet D) and the AME/QME process (Fact Sheet E), and posted them on its website. Yet the Division failed to note that the new PD fact sheets (in English and Spanish), dated March 2013, were corrected versions of the ones it released Feb. 7 (DWC Newsline 06-13) with instructions to claims operations that they had to begin distributing them by March 18. Thus, any claims administrator who followed that directive is now using incorrect & outdated PD Fact Sheets. Claims administrators should not be subject to audit penalties or adverse rulings by WCALJs for use of obsolete information if the DWC has not advised them that the information has been changed, and they should be given 30 working days from the date that the DWC posts a Newsline announcing the changes to update their systems and begin distributing the revised information.

Discussion

While it is essential to move from the fact sheets to an electronic format, the DWC must maintain current information on the website in order to avoid misinforming the injured worker. Statutory changes, new regulations, and case law changes must be posted immediately so that obsolete or conflicting information is not provided. In addition, because many claims administrators incorporate the information developed by the Division into their own notices, it is essential that whenever DWC makes a change, claims administrators are notified and given a grace period of 30 working days to update their systems and to begin distributing the revised information. It is not unusual for disputes to arise regarding specific information that the injured worker did or did not have at a specific point in time. If the DWC website is to become a prime informational resource, then every revised version must be archived and accessible, and the effective date for using the information must be noted to establish the information available at any given point in time for the resolution of future litigation.

Section 9810 -- General Provisions

Recommendation

(i) Any deadline for reply which is measured from the date a notice is sent, and all rights protected within the deadline, are extended if the notice is sent by mail, or electronically. **If the notice is sent by mail, the** The deadline is extended as follows: by 5 days if the place of mailing and the place of address are in the same state of the United States; by 10 days if the place of mailing and the place of address are in different states of the United States; by 20 days if the place of mailing is in and the place of address is outside the United States. All notices shall be mailed from the United States. **If the notice is sent electronically, the deadline is extended by two days.**

Discussion

CCR Title 8, Article 6, section 10507 addresses the time within which to serve documents by mail, fax, or e-mail. Section 10507(a) sets forth the relevant time extension whether the document is served by mail, fax, or e-mail. A separate 2-day extension is not included for electronic service and should not be included here.

Section 9812 - Benefit Payment and Notice

Recommendation

(a)(2)(A)(2), (d)(1)(C), and (e)(2)(A)(3) -- Remove the extensive description of the panel QME process from the benefit notice and add it to the QME panel request form.

Discussion

Several subdivisions in section 9812 require a detailed explanation of the panel QME process. While the language has been shortened, it is still lengthy, complex, and potentially confusing. This information might be more appropriately included in the QME panel request forms. The QME panel request form can begin with an instruction page explaining how the process works. A simple, short notice advising the employee of the right to a panel QME and the need to submit the form to the state within 10 days with a reference to the form will be sufficient to direct the employee and none of the instructions will be lost.

Section 9812 -- Benefit Payment and Notice

Recommendation

In the subdivisions that include the employee's right to receive supporting medical reports – (a)(3), (d), (e)(2), (e)(3), and (g) – the notice should read:

If the claims administrator's determination is based on a medical report, **the employee shall either be notified that he or she may request a copy of the report or** a copy of the medical report shall be provided with the notice, except for psychiatric reports that the psychiatrist has recommended not be provided to the employee.

Discussion

The statute provides that the injured worker may request supporting medical evidence for the benefit decisions made by the employer or the claims administrator. The option to provide these reports on request or to send them is, therefore, in line with the statute and will streamline the benefit notice process.

Section 9812 -- Benefit Payment and Notice

Recommendation

(e)(1) Delete subdivision (1) and renumber the remaining subdivisions.

Recommendation – Add to subdivision (d):

(d) Notice that Benefits Are Ending (TD, PD). With the last payment of temporary disability indemnity, or permanent disability indemnity, the claims administrator shall advise the employee of the ending of indemnity payments and the reason, and shall make an accounting of all compensation paid to or on behalf of the employee in the species of benefit to which the notice refers, including the dates and amounts paid and any related penalties. **If at the ending of temporary disability, the claims administrator has not received a medical report finding the employee's condition to be permanent and stationary, the claims administrator shall advise that**

the employee will receive information about the existence and extent of permanent disability when the claims administrator receives a medical report finding the employee's condition to be permanent and stationary. If the decision to end payment of indemnity was made after the last payment, the claims administrator shall send the notice and accounting within 14 days of the last payment. If the claims administrator's determination is based on a medical report, a copy of the medical report shall be provided with the notice, except for psychiatric reports that the psychiatrist has recommended not be provided to the employee.

Section 9812 -- Benefit Payment and Notice

Recommendation

(e)(3) Notice That No Permanent Disability Exists. If In cases where the employee has sustained compensable lost time from work, if the claims administrator alleges that the injury has caused no permanent disability in a case where either the employee has received payment of temporary disability indemnity or the employee claims permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable. ...

Discussion

This clarification is necessary to ensure that the requirement to send a notice that no permanent disability exists applies only where the employee has lost time from work due to his injury or illness, and does not apply to medical-only cases.

Section 9812 -- Benefit Payment and Notice

Recommendation

(e)(4) Notice of Permanent Disability Indemnity Payment. Together with Within 5 business days of the first payment of permanent disability indemnity, the claims administrator shall advise the employee of the weekly permanent disability indemnity payment, how it was calculated, the duration and schedule of payments, and the claims administrator's reasonable estimate of permanent disability indemnity to be paid.

Discussion

Most claims organizations process and send benefit checks from one location and distribute the related benefit notices from a different location, making simultaneous delivery impractical and unfeasible. The recommendation provides an adequate time to process and deliver both the benefit check and the notice to the injured worker.

Section 9812 -- Benefit Payment and Notice

Recommendation

(i) ... If an unrepresented employee requests the form, the claims administrator shall acknowledge receipt of the employee's objection within five ten business days of receipt of the objection, and shall provide the employee with a copy of the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators.

Discussion

A period of ten business days is more realistic to accomplish this communication and is still reasonably prompt.

Notice to Employees Poster

Section 9881.1 -- Notice to Employees Poster.

Recommendation

Retain current language and update only where necessary to conform to SB 863 changes or to make necessary clarifications.

Discussion

The Division has erred here on the side of brevity at the expense of required information that helps inform employees and reduces the likelihood that employers may be challenged for not providing sufficient notice about workers' compensation benefits, time frames or other rights and obligations. The draft language is not as complete, helpful and clear as the existing language. While the draft language is simple, it lacks important details. So much information has been removed that the draft poster no longer meets the minimum requirements of Labor Code sections 132, 3550, 4616.3 and CCR section 9881. Deficiencies include, but are not limited to, the following examples.

- LC Section 3550 (d) (4) and CCR section 9881(c)(7) require the notice to include “information on the rights of the employee to select and change the treating physician pursuant to the provisions of Section 4600.”
The proposed language only includes one line which notes that “After the first visit, you may be allowed to change to a different doctor as your primary treating physician.” This is incomplete and inadequate, as it only describes the situation if the worker is covered by an MPN, and unlike the current language, it offers no information on how that process works. Furthermore, unlike the current language, no information is given on the employer's 30-day medical control and the employee's rights under LC section 4600 to change physicians if they are not in an MPN, or their rights if they are in an HCO, have a predesignated personal physician or named a personal chiropractor or acupuncturist.
- LC Section 3550 (d)(5) and CCR Section 9881(c)(8) require the posting notice to include: *“The rights of the employee to receive temporary disability, permanent disability, supplemental job displacement, and death benefits as appropriate.”*
The proposed language provides no meaningful or appropriate description or explanation of the employee rights to such benefits. There is little to no mention of the nature and scope of those benefits. It merely says that *“benefits can include...”*, followed by a terse, incomplete definition of each benefit. For example, the only information on permanent disability is that benefits can include “Permanent disability (PD) benefits if you don't recover completely,” while the only information on SJDB is that it is “to help pay for retraining or skill enhancement.” This leaves the employee with little to no information on what those benefits consist of, when they are appropriate, criteria for qualifying, the amounts, the limitations, how and by whom they are determined, when and how they are delivered, or what to expect.

While the current version of the posting notice doesn't provide complete explanations of these benefits, it does at least provide more information on the employee's rights to each benefit and when they are appropriate.

- The “False Claims and False Denials” section has been removed from the proposed poster. The Institute believes that this information is critical because it informs employees and employers alike that:
“Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony and may be fined and imprisoned.”
 This serves to both discourage fraud of all types and to alert employees and employers alike that they have a right to remedies if it does occur
- The draft does not mention the Return to Work Fund enacted by SB 863, which, while not a workers’ compensation benefit per se, is a benefit that the injured employee may have a right to. In fact, this \$20 million fund was the key to the passage of SB 863, as it provided the mechanism for increasing payments to injured workers who suffer a disproportionate wage loss following the PD award. Notably, when CWCI was drafting its version of the Posting Notice last fall, the Division required that a basic description of the Return to Work Fund be included, so it is ironic that it has been excluded from the Division’s own version of the posting notice.
- The information currently outlined in “*If You Get Hurt*” more completely and specifically adheres to the requirements in Labor Code sections 4600, 4616.3(b), 3550 and CCR 9881. There are also time limits in statute and case law for reporting the injury, other than the 30 days mentioned in the draft.
- The format of information in the current “Questions?” section, which does not require employers to constantly update the poster due to personnel changes, is preferable to the proposed format, which would require employers to continually monitor and refresh the contact information to make sure it is not outdated.

Section 10139 -- Workers’ Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Workers’ Compensation Claim Form (DWC 1)

Recommendations

.... An explanation of workers’ compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and retain this notice for future reference.

Discussion

The recommended changes will clarify for the injured employee that the Notice of Potential Eligibility is the explanation referenced here, and that this notice should be retained for his or her future reference.

Recommendations

Switch lines 8 and 9 in the Employee section of the DWC-1 Claim Form and renumber the subsequent items in the Employer section to 10 through 19.

Discussion

The employee's signature should follow the employee's agreement to receive notices by email and should be the final line in the Employee section.

Notice of Potential Eligibility (NOPE)**Recommendation**

Retain current language and update only where necessary to conform to SB 863 changes or to make necessary clarifications.

Discussion

The Division has erred here, too, on the side of brevity at the expense of required and helpful information. The NOPE was adopted as a cover sheet to the DWC-1 after state lawmakers passed AB 749 in 2002, which among other things, eliminated the statutory requirement that claims administrators include a pamphlet explaining a workers' benefits and obligations with the first notice of payment or notice of delay. Supplanting the injured worker pamphlet with the NOPE streamlined the notice process because the injured worker was already receiving a DWC-1, and making the NOPE a tear-off cover sheet to be retained by the injured worker assured that anyone who was given a claim form was provided with current information on their rights and benefits. While this information should be clearly written and understandable, it needs to give the injured worker a good idea of how the claim process should unfold, what benefits they may expect, applicable timeframes and limits, and how to address problems – the same types of information that used to be provided in the injured worker pamphlet.

As with the proposed posting notice language, the draft language on the revised NOPE is not as complete, helpful and clear as the existing language. Although the draft language is simple, it is over-generalized, poorly organized, uses language that sets an adversarial tone, includes incorrect, unnecessary, and redundant information, deletes important elements, and will fail to sufficiently inform employees and employers of their rights, obligations, benefits and what to expect. So much information has been removed that the notice no longer meets the minimum requirements of Labor Code sections 132, 5401(b)(2), 4616.3 and CCR section 9881. Failure to provide adequate information on employee rights such as timeframes, benefits, predesignation, and how to change physicians leaves employers vulnerable to litigation, the consequences of which may include loss of medical control, liability for additional benefits, and the tolling of the statute of limitation for filing claims. Because the Notice of Potential Eligibility is given to the employee along with the claim form, providing more complete information in the NOPE will ensure that injured employees are adequately informed in these areas and that employers are protected from liability for failing to inform injured employees.

The proposed NOPE is vastly inferior to the current version. The Institute strongly recommends retaining the current NOPE with revisions limited to updates focused on SB 863 changes.

California Chamber of Commerce

Jason Schmelzer
California Coalition on Workers' Compensation

§ 9810 - General Provisions

This section now mandates that all notice letters contain the claims administrator's web address. However, this section fails to recognize that many claims administrators do not have a website. In particular, this requirement affects self-insured employers who often do not maintain an external facing website dedicated to workers' compensation. We recommend that this requirement is removed and offer the following language:

(c) Benefit notice letters, excepting those notices whose language or format are set forth in statute or where a specific notice form has been adopted as a regulation, may be produced on the claims administrator's letterhead. Unless sent on the claims administrator's letterhead, all All notice letters shall identify the claims administrator's name, mailing address, telephone number and website address if applicable, the employee's name, employer's name, the claim number, the date the notice was sent to the employee, and the date of injury. All notices shall clearly identify the name and telephone number and mailing address of the individual claims examiner responsible for the payment and adjusting of the claim, and shall include a notation if one or more attachments are being sent with the notice. and All notices shall clearly state that additional information may be obtained from an Information and Assistance officer with the Division of Workers' Compensation, or on the Division's website: www.dwc.ca.gov. If the employer offers additional disability benefits in addition to those provided by law under workers' compensation, the claims administrator may incorporate the information within the notices required by these regulations. A single benefit notice may encompass multiple events.

§9881.1 Notice to Employees Poster

The new poster's insurance information section would now require an employer to list an "Employer contact person." This proposed change is problematic and will add cost and additional administrative burden. As work forces are not static, an employer's designated contact person will change when this person moves into a new role or leaves the company. Each time this occurs, employers will be required to update every poster. For some employers this would mean updating posters at hundreds of different posting locations. Our organizations urge the DWC to remove the "Employer Contact Person" from the poster requirement.

§9810 General Provisions; §9812 Benefit Payment and Notice

Our organizations have reviewed the letter submitted to the DWC by the California Workers' Compensation Institute (CWCI) dated May 3, 2013, that provides commentary on the benefit notices and support the proposals contained therein. Specifically, our organizations support the recommended changes to: (1) Section 9810 regarding the Safe Harbor and the DWC website; (2) Section 9812 regarding notices on the timeline to distribute benefit checks and notice to the injured worker; and (3) Section 9812 regarding notices pertaining to the QME process.

1. Any amendments to benefit notice regulations must conform to the provisions of AB 335, a 2011 bill that amended Labor Code §138.4. Subdivision (c) of that section was amended to require that specified notices include notice of the right to consult with an attorney, where appropriate. For reference purposes, subdivision (c) now reads (emphasis added):

(c) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall prescribe reasonable rules and regulations, *including notice of the right to consult with an attorney, where appropriate*, for serving on the employee (or employee's dependents, in the case of death), the following:

(1) Notices dealing with the payment, nonpayment, or delay in payment of temporary disability, permanent disability, supplemental job displacement, and death benefits.

(2) Notices of any change in the amount or type of benefits being provided, the termination of benefits, the rejection of any liability for compensation, and an accounting of benefits paid.

(3) Notices of rights to select the primary treating physician, written continuity of care policies, requests for a comprehensive medical evaluation, and offers of regular, modified, or alternative work.

In order to comply with this new requirement, we recommend that subdivision (d) of section 9810 be amended to require that the mandatory statement of the employee's remedies, which is required to be included in all benefit notices, must include notice of the right to consult with an attorney, as follows:

"You have the right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call me, (insert adjuster's name and telephone number). You also have the right to consult with an attorney of your choice. If you are represented by an attorney, if you have questions you should call your attorney, not me."

2. These draft rules eliminate all requirements to provide DWC informative pamphlets with notices. This proposed change appears to be based on the 2010 CHSWC "Report on Benefit Notices and Recommendations."

One of the principal recommendations of that CHSWC report was a proposal to amend §138.4 to require development of a booklet describing the overall workers' compensation claims process. Although that specific recommendation was not adopted, AB 335 did amend §138.4, subdivision (d), to require that the AD, in consultation with CHSWC, develop and make accessible both on its website and at district offices "informational material" Further, under subdivision (e), each notice prescribed by the AD must "reference the informational material ... to enable employees to understand the context of the notices and shall clearly state the Internet Web site address and contact information that an employee may use to access the informational material."

We see no provision in the rules identifying or defining what informational materials have been developed and made available on the DWC website and district offices, no rules requiring notices to reference the available informational material, and no provision that requires notices to include instructions to the employee on how to access the informational material. Consequently, these draft rules do not comply with the requirements of §138.4 and must be significantly revised.

In that regard, we would like to provide some general comments. As noted above, the 2010 CHSWC proposal was to require that employees be provided access to a general booklet describing the workers' compensation system. Although that specific recommendation was not adopted, CHSWC has prepared a Guidebook for Injured Workers that is available both through its website and through the DWC website. We believe this booklet is an excellent resource for injured employees and hope that its availability on the internet will help many employees in their efforts to navigate this complex and difficult system.

If it is the intent that this booklet will be at least part of the "informational materials" available to injured employees, the rules should mandate that every notice inform injured employees of the existence and availability of this document. This requires much more than inclusion of a simple statement that "more information is available at this website _____ ." The statute, §138.4, requires that the employee "understand the context of the notices...." In many cases employees will be receiving notices years after the initial filing of a claim, and without sufficient information the employee will not be in a position to "understand the context" of these notices. Thus, new rules should require that every notice include a basic explanation of the employee's rights and responsibilities with respect to that notice, along with information on how to access the informational material developed by the AD (the booklet, if that is the primary document) .

In addition, for informational material that is to be provided through the internet, the rules must set out *an easily accomplished process* for employees to access this material. Note that we have highlighted the fact that it must be "easy" to access the information. Simply providing a general website address that forces the employee to navigate through multiple screens, or requiring input of a long and complex internet address, would effectively bar many employees from accessing this critical information. One way to help some employees access the proper information would be to require that all notices include a QR code (sometimes called a "scan box") that would link directly to the appropriate informational material.

Furthermore, although we support making as much information as possible available on the internet, it must be recognized that significant segments of the injured employee population do

not have ready access to computers and the internet. Many employees, including older employees, laborers, or farmworkers, do not use computers in their jobs and have little or no familiarity with computers. Some employees have language problems, and although we understand the booklet will be printed in Spanish, that will not help an employee trying to find and navigate through the correct internet site, nor does it help the thousands of employees in California whose first language is other than English or Spanish. And many injured employees find that their work injury precipitates a financial catastrophe, and personal computers become an unaffordable luxury.

Accordingly, in order to comply with the statutory requirement that each notice must "clearly state ... contact information that an employee may use to access the informational material," we strongly urge that revised benefit notice rules include a requirement that all notices must include a toll-free telephone number and address for the employee to request a written copy of the informational material.

3. We are extremely concerned that many injured employees could lose important rights under these proposed rules because they are not informed of statutory time limits and other requirements relating to requests for QME panels. For example, under §9812(a)(3) [page 8 of the draft rules] the adjuster is required to provide a notice of denial of a TD payment within 14 days after the determination to deny was made. If the denial is related to a medical issue and the adjuster agrees with the physician's evaluation, the notice must advise the employee that he or she must contact the adjuster "within the applicable time limit prescribed in Labor Code section 4062(a)" to obtain a form to request a QME panel. However, because the adjuster may not make the TD determination until days after receipt of the medical report, if the notice of denial is not sent to the employee until 14 days later, much or all of the 30 day statutory time period for an unrepresented employee to object to that report may have already expired by the time the employee receives this notice.

The same problem can occur when the adjuster sends a notice that benefits are ending [§9812(d), page 10], that permanent disability exists [§9812(e)(2)(a)2, page 18], or that no permanent disability exists [§9812(e)(3)(a)3, page 21]. Where an employee may lose an important right due to a statutory time limit, these rules should require a severely shortened time period for the claim adjuster to provide these notices to the employee.

In addition, in each of these situations where the claim adjuster does not agree with the physician's evaluation, the adjuster is required to include with the notice a copy of the form to request assignment of a QME panel. Current rules require that the notice contain a warning to the employee printed at the top of the first page warning the employee that he or she may lose important rights if no action is taken within 10 days. The proposed rules require that the same information be provided in the body of the notice. Although we appreciate that the proposal provides a more expansive explanation of the statutory time limits for the employee to act, it is a simple fact that many employees will miss this warning if it is buried in the body of the notice. Consequently, we strongly urge that the rules require this information to be much more prominent on the notice. It appears that it is intended the words "**10 days**" be printed in bolded print, but this is unclear from the proposed draft. We recommend that the rules explicitly state that the entire required statement must be printed in bolded print, or otherwise highlighted by

color, type size, or underlining, and that this warning paragraph must be prominently displayed at or near the top of the form.

4. Under §9810(h) [which is current §9810(f)] the claims administrator is required to send a copy of each benefit notice concurrently to the attorney of a represented employee. In view of the movement of our system to a "paperless" system, we suggest that this rule be amended to allow electronic provision of notices if requested by the attorney.

5. Proposed new language in several sections refers to a claim administrator's determination based on "a medical report" or "a comprehensive medical evaluation." However, as recognized in Section 9810(g) [which is current §9810(e)], there can be multiple reports or evaluations that may have been relied upon. We suggest that the draft language be amended to refer to "medical report(s)" and "comprehensive medical evaluation(s)."

6. Section 9810(c) proposes that the website address of the claim administrator be added to all benefit notices. We support this change, although as noted earlier any website address must be easily accessed by the employee. Giving, for example, the general website address for an insurance company will be of no help to anyone. Furthermore, we strongly urge that the rule be amended to require that the notice also include the email address of the claim administrator. The rules already require inclusion of the telephone number and address of the individual examiner responsible for adjusting the claim; adding a requirement to provide the email address will update the rule to reflect current business practices.

Victoria Katz, Rules Attorney
Aderant

May 2, 2013

We would like to comment on the revised benefit notice regulations. In particular, it appears that the new 8 CCR 9810(i), regarding the extension of deadlines when notices are sent electronically, conflicts with 8 CCR 10507(a). As proposed, 9810(i) says:

Any deadline for reply which is measured from the date a notice is sent, and all rights protected within the deadline, are extended if the notice is sent by mail, or electronically. If the notice is sent by mail, the deadline is extended as follows: by 5 days if the place of mailing and the place of address are in the same state of the United States; by 10 days if the place of mailing and the place of address are in different states of the United States; by 20 days if the place of mailing is in and the place of address is outside the United States. All notices shall be mailed from the United States. If the notice is sent electronically, the deadline is extended by two days. [Emphasis added.]

At the same time, 8 CCR 10507(a) says:

(a) If a document is served by mail, fax, e-mail, or any method other than personal service, the period of time for exercising or performing any right or duty to act or respond shall be extended by:

(1) five calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is within California;

(2) ten calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is outside of California but within the United States; and

(3) twenty calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is outside the United States.
[Emphasis added.]

We understand that section 9810 refers to replies to notices sent and section 10507 refers to documents served in matters before the Worker' Compensation Appeals Board, but calculating time differently in the two situations may potentially lead to great confusion among practitioners. Did the DWC intend for different time rules to apply depending on the type of document served or the phase of the workers' compensation matter? To avoid confusion and promote consistency, we propose that the DWC revise the regulations so that a single standard for time computation applies to all DWC matters.

Moreover, if the DWC does intend to extend reply deadlines by "two days," we propose that it be specified whether the days should be counted as calendar days or business days. With respect to California state civil courts, CRC 2.251(f)(2) provides that deadlines following service by electronic means are extended by two "court" days. Because section 9810 does not specify calendar or court/business days, it is ambiguous here whether the DWC intended to reflect that same standard, or whether it meant the extension to be counted instead in calendar days.

Steven Suchil, Assistant Vice President/Counsel
American Insurance Association

May 2, 2013

Introduction:

We wish to complement the Division on simplifying these regulations and the various notices. There have been multiple instances of injured employees voicing confusion with some of the notices with the attached Fact Sheets and other enclosures. We expect this streamlining of the notices to provide a vast improvement for all concerned.

Comments on individual sections are provided below.

Suggestions for added language are highlighted and shown with underline and deletion with ~~strikethrough~~.

Section 9810

Section 9810 (b) states:

The Administrative Director may issue and revise from time to time a Benefit Notice Instruction Manual as a guide for completing and serving the notices required by this Article.

We recommend that these manuals and the sample notices be posted on the DWC website mentioned in Section 9810 (e), and archived with respect to content and dates of revision. Further, we request for clarification that if a Claims Administrator utilizes the correct sample notice with the appropriate revision date, no audit penalty will apply.

Section 9810(l) states that notices can be sent to an injured employee via e-mail if they choose this mode of transmission, and we support this option. The proposed regulation, however, does not speak to electronic transmissions from the injured employee. We suggest clarification to indicate that other means of transmission may be used by the employee to communicate with the Claims Administrator. Especially with respect to time sensitive responses because an individual's e-mail in-box may be unattended for periods of time because of illness, vacation or other prolonged absences. If this recommended clarification is made here it should also be made on the Claim Form.

Section 9812

We recommend the following changes to subdivision (a) (2) (A) (2):

If no comprehensive medical evaluation has taken place, the notice shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. When providing the form to request a panel of Qualified Medical Evaluators, the notice shall include the following statement: "To resolve this issue and allow me to make a determination on your entitlement to benefits, a comprehensive medical evaluation is needed. Enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three qualified medical evaluators (QMEs). If you do not submit the form within **10 days**, we will have the right to submit the form. ~~In addition, within 10 days after the DWC sends you a panel, you must select a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform me of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform me of your choice, we will choose the QME who will examine you and we will arrange the appointment.~~ See the instructions on the enclosed form for additional information about this process.

We believe that the DWC should create an instructions section as part of the Panel Request form and add the material we have deleted from the above subdivision to that document. If the Division accepts this recommendation be reflected in Section 9812 (d) (1) (c) and (e) (2) (A) (3). We believe that reducing the multi-step instruction in the Notice letter itself will reduce

reader confusion and concern regarding what sounds like a complex and somewhat advisarial process.

Subdivision (e) (4) should be amended as follows:

Notice of Permanent Disability Indemnity Payment. ~~Together with~~ Within five (5) days of the first payment of permanent disability indemnity, the claims administrator shall advise the employee of the weekly permanent disability indemnity payment, how it was calculated, the duration and schedule of payments, and the claims administrator's reasonable estimate of permanent disability indemnity to be paid.

The above revision should be made because for many Claims Administration entities, the Indemnity payments and notices originate from different locations. Having to gather both items for transmitting to the injured employee slows the process of getting the actual benefit payment to the injured employee.

We recommend the following change to subdivision (e)(3):

Notice That No Permanent Disability Exists. In cases where the employee has sustained compensable lost time from work, if ~~if~~ the claims administrator alleges that the injury has caused no permanent disability in a case where either the employee has received payment of temporary disability indemnity or the employee claims permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable. This notice shall be sent together with the last payment of temporary disability indemnity or within 14 days after the claims administrator determines that the injury has caused no permanent disability. If the claims administrator's determination is based on a medical report, a copy of the medical report shall be provided with the notice, except for psychiatric reports that the psychiatrist has recommended not be provided to the employee.

This proposed clarification is necessary to ensure that the requirement to send a notice that no permanent disability exists does not apply to Medical Only cases. The notice need only be sent when the employee has lost time from work due to his/her injury or illness.

Subdivision (g) (4) should be changed to read:

A copy of the Notice Denying Liability for All Compensation Benefits shall be served on all lien claimants, all claims for cost claimants, and all persons or entities that have been authorized by the claims administrator to furnish benefits, goods or services for which a lien or claim for cost may be filed under Labor Code sections 4903 through 4906, inclusive.”

We believe the above addition should be made to comply with the statutory relationship of the two entities.

The following change is recommended for subdivision (i):

Provision of QME Panel Request Form. An unrepresented employee may object to a medical determination made by a treating physician by requesting the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. If an unrepresented employee requests the form, the claims administrator shall acknowledge receipt of the employee's objection within **five ten** business days of receipt of the objection, and shall provide the employee with a copy of the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators.

We are requesting an extension of the five business days in order to allow adequate time for compliance.

Notice to Employees Poster

The following change should be made:

Discrimination: ~~Is it~~ **It is** illegal for your employer to punish or fire you for having a job injury or illness, filing a claim, or testifying in another person's workers' compensation case. If proven, you may be reinstated and reimbursed for lost wages and work benefits.

Workers' Compensation Claim Form (DWC 1) and Notice of Potential Eligibility

In the third bullet of the Switching To A Different Doctor section, we recommend the following change:

If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to **a** doctor of your choice if your employer or the claims administrator has not created or selected an MPN.

Dennis Knotts

May 1, 2013

The proposed Benefit Regulations for the Delay of Temporary Disability Benefits and for the Delay of the entire Claim continues to misrepresent what is clearly taught by the Labor Code and is, therefore, in conflict with the Labor Code(s). As such, the Administrative Director lacks the legal authority to make these Regulations.

In 9812 (a)(2)(A) there is discussion of where a Delay of TTD Benefits is due to a medical issue. The employee is to be provided a QME 105 form to request a PQME to address the need for TTD. If represented the employee is instructed to contact his/her attorney.

The Labor Codes relating to comprehensive medical-legal evaluations are 4060, 4061 and 4062. The Labor Code for unrepresented medical evaluations is 4062.1.

A careful reading of 4062.1 (b) cites: "If either party requests a medical evaluation pursuant to Section 4060, 4061, or 4062..." The Labor Code then instructs the party to follow the PQME process.

However, a reading of the cited Labor Codes reveals the following:

Labor Code 4060 (b): "Neither the employer nor the employee shall be liable for any comprehensive medical evaluation performed by other than the treating physician..."

Labor Code 4061(c) "If the parties do not agree to a permanent disability rating based upon the treating physician's evaluation..."

Labor Code 4062 (a) "If either the employee or employer objects to a medical determination made by the treating physician..."

The three Labor Codes cited by 4062.1 (b) clearly authorize the treating physician to be the party to make the initial medical determination.

What has been sorely lacking from the Benefit Notice Regulations is clear direction as to the hierarchy of medical opinions for the decisions. The Labor Code authorizes the employer to use the treating physician to make the initial medical determination. THEN if there is a dispute, the matter moves to the PQME/AME route. This is because the PQME/AME route is the "DISPUTE RESOLUTION" process. You cannot activate the Dispute Resolution process until there is a dispute. There is not a dispute until a decision is made. The employer is allowed to conduct its own investigation and to make its own decision before activating the Dispute Resolution process.

You need clear wording in the Regulations something along these lines:

"The employer is allowed to conduct its own investigation into the issues of compensability and entitlement to benefits of any claim. This investigation might include medical issues. As such, the employer is permitted to choose to use the treating physician to make the initial determination into these issues. Once the treating physician has issued his/her determination; if there is a dispute, the matter shall be resolved according to Labor Code 4062.1 or 4062.2 if the employee is represented."

Any Regulation that does not allow the employer to use the treating physician to make the initial determination concerning any medical issue - including causation - contradicts Labor Codes 4060, 4061 and 4062 and would, therefore, be invalid.

The proposed Regulation relating to Delay of Permanent Disability Benefits 9812 (e)(1), contradicts Labor Code 4650 (b). As such, the Administrative Director lacks the legal authority

to authorize employers to delay Permanent Disability Benefits except for those cases outlined in SB 863 where the employee is working at a job earning 85% or 100% of the pre-injury salary.

In 2004, the Legislature created a 104-week cap on Temporary Disability Benefits. This creates the potential scenario where an employee can still be temporarily disabled, but is no longer entitled to benefits. Question: what is the employee to live on? The answer was implied that they would shift over to Permanent Disability Advances. Labor Code 4650 (b) [now 4650 (b)(1)] States:

"...When the last payment of temporary disability indemnity has been made... and REGARDLESS of whether the extent of permanent disability can be determined AT THAT DATE; the employer NEVERTHELESS shall commence the timely payment required by this subdivision..." [Emphasis added, but these were changes introduced by SB 899 in 2004]

As of SB 899 passed 4/19/2004 the employer lost the right to delay Permanent Disability Benefits. The employer would either begin the advances or deny the benefit altogether. With the passing of SB 863 the employer was specifically given the right to defer the Permanent Disability Advances until the employee was found Permanent and Stationary [i.e. a determination of the level of PD was made] in only those cases where the employee was in a modified/alternate employment [85% of the pre-injury salary] or back at his/her regular job [earning 100% of the pre-injury salary]. This distinction and clarification is sorely lack in the proposed Regulations.

Finally, in 9812 (g) - the Denial of All Benefits you specifically list "including medical-only claims."

This seems to be a "throw-back" to a practice former Administrative Director - the late Carrie Nevans - attempted to introduce to create Benefit Notices for medical only claims. The entire concept is that in order to qualify for Benefit Notices there must be a payment or an entitlement of some form of indemnity benefits: i.e. TTD, PD or Death Benefits. This elevates all these claims to the indemnity claim status. Labor Code 4650 outlines the issuing of Delay Notices in relation to Temporary Disability Benefits and Permanent Disability Benefits. There is nothing in the Labor Code requiring any kind of Benefit Notice to be sent on any First Aid or Medical Only Claim. As such, this section of the proposed Regulation is made without Labor Code authority and invalidates the section of Regulations proposed.

This Regulation also ignores the practice of converting Medical Only Claims to Indemnity Claims where they must be delayed or denied. A Claims Adjuster must either have passed the State Self-Insurance test or be working under the license of an Adjuster who passed the State Self-Insurance test to sign Benefit Notices - including Denials. Medical Only Claims Adjusters rarely have taken or passed the Self-Insurance Test. This Regulation creates confusion and may accidentally authorize a Medical Only Claims Adjuster to perform an action they are not authorized to do.

It would make more sense to establish the practice state-wide for the following:

"Where a First Aid or Medical Only Claims is being delayed or denied; that claim must be converted to an Indemnity Claim and all Benefits Notices required for the Indemnity Claim shall be issued by the employer."

As it is currently worded, it not only creates confusion for the industry; but it may contradict other Regulations and/or Labor Codes and there is no authority in the Labor Code to allow the practice being proposed.

Joseph Shannis, Senior Claims Representative
Republic Indemnity

May 1, 2013

SECTION 9812 (e)(2)(A) 1. – 3. Notice that Permanent Disability Exists

These regulations indicate that for an unrepresented employee, the notice shall advise the employee of ONE of the following three options: The first option (1.) pertains to the right to have the treating physician's report rated by the DEU. The other two options (2. and 3.) relate to whether or not the claims administrator agrees or disagrees with the evaluation, and the subsequent rights of the employee in either case. The way the proposed regulation is written, the administrator must choose one of these three options to include in the notice.

Recommendation: It seems likely the intent was to include the language regarding the right to a DEU rating (option 1.) in all instances, with the optional language for the notice limited to either 2. or 3. depending on whether the claims administrator agrees or disagrees with the evaluation.

SECTION 9812 (e)(3)(A) 1. – 4. Notice that No Permanent Disability Exists

Same issue as above, although in this instance there are four options from which ONE must be chosen. The language relating to the DEU rating of the report is option 2.

GRACE PERIOD

Due to the complexity and extent of changes being proposed to all the Benefit Notices we feel a grace period of six months from the effective date of the regulations would be reasonable based on our past experience dealing with similar programming and implementation challenges.