

**Chapter 4.5. Division of Workers' Compensation**  
**Subchapter 1. Administrative Director -- Administrative Rules**  
**Article 3.5. Medical Provider Networks**

**Section 9767.1 Medical Provider Networks – Definitions:**

(a) As used in this article:

(1) “Ancillary services” means any provision of medical services or goods as allowed in Labor Code section 4600 by a non-physician.

(2) “Cessation of use” means the discontinued use of an implemented MPN that continues to do business.

(3) “Covered employee” means an employee or former employee whose employer has ongoing workers’ compensation obligations and whose employer or employer’s insurer has established a Medical Provider Network for the provision of medical treatment to injured employees unless:

(A) the injured employee has properly designated a personal physician pursuant to Labor Code section 4600(d) by notice to the employer prior to the date of injury, or;

(B) the injured employee’s employment with the employer is covered by an agreement providing medical treatment for the injured employee and the agreement is validly established under Labor Code section 3201.5, 3201.7 and/or 3201.81.

(4) “Division” means the Division of Workers’ Compensation.

(5) “Economic profiling” means any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

(6) “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(7) “Employer” means a self-insured employer, the Self-Insurer’s Security Fund, a group of self-insured employers pursuant to Labor Code section 3700(b) and as defined by Title 8, California Code of Regulations, section 15201(s), a joint powers authority, or the state.

(8) “Group Disability Insurance Policy” means an entity designated pursuant to Labor Code section 4616.7(c).

(9) “Health Care Organization” means an entity designated pursuant to Labor Code section 4616.7(a).

(10) “Health Care Service Plan” means an entity designated pursuant to Labor Code section 4616.7(b).

(11) “Insurer” means an insurer admitted to transact workers’ compensation insurance in the state of California, California Insurance Guarantee Association, or the State Compensation Insurance Fund.

(12) “Medical Provider Network” (“MPN”) means any entity or group of providers approved as a Medical Provider Network by the Administrative Director pursuant to Labor Code sections 4616 to 4616.7 and this article.

(13) “Medical Provider Network Plan” means an employer’s or insurer’s detailed description for a medical provider network contained in an application submitted to the Administrative Director by a MPN applicant.

(14) “MPN Applicant” means an insurer or employer as defined in subdivisions (7) and (11) of this section.

(15) “MPN Contact” means the individual(s) designated by the MPN Applicant in the employee notification who is responsible for answering employees’ questions about the Medical Provider Network and is responsible for assisting the employee in arranging for an independent medical review.

(16) “Nonoccupational Medicine” means the diagnosis or treatment of any injury or disease not arising out of and in the course of employment.

(17) “Occupational Medicine” means the diagnosis or treatment of any injury or disease arising out of and in the course of employment.

(18) “Physician primarily engaged in treatment of nonoccupational injuries” means a provider who spends more than 50 percent of his/her practice time providing non-occupational medical services.

(19) “Primary treating physician” means a primary treating physician within the medical provider network and as defined by section 9785(a)(1).

(20) “Provider” means a physician as described in Labor Code section 3209.3 or other provider as described in Labor Code section 3209.5.

(21) “Regional area listing” means either:

A) a listing of all MPN providers within a 15-mile radius of an employee’s worksite and/or residence; or

B) a listing of all MPN providers in the county where the employee resides and/or works if  
1. the employer or insurer cannot produce a provider listing based on a mile radius  
or 2. by choice of the employer or insurer, or upon request of the employee.

C) If the listing described in either (A) or (B) does not provide a minimum of three physicians of each specialty, then the listing shall be expanded by adjacent counties or by 5-mile increments until the minimum number of physicians per specialty are met.

(22) “Residence” means the covered employee’s primary residence.

(23) “Second Opinion” means an opinion rendered by a medical provider network physician after an in person examination to address an employee’s dispute over either the diagnosis or the treatment prescribed by the treating physician.

(24) “Taft-Hartley health and welfare fund” means an entity designated pursuant to Labor Code section 4616.7(d).

(25) “Termination” means the discontinued use of an implemented MPN that ceases to do business.

(26) “Third Opinion” means an opinion rendered by a medical provider network physician after an in person examination to address an employee’s dispute over either the diagnosis or the treatment prescribed by either the treating physician or physician rendering the second opinion.

(27) “Treating physician” means any physician within the MPN applicant’s medical provider network other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(28) “Workplace” means the geographic location where the covered employee is regularly employed.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 1063.1, 3208, 3209.3, 3209.5, 3700, 3702, 3743, 4616, 4616.1, 4616.3, 4616.5 and 4616.7, Labor Code; *California Insurance Guarantee Association v. Division of Workers’ Compensation* (April 26, 2005) WCAB No. Misc. #249.

### **9767.16 Notice of Employee Rights Upon Termination or Cessation of Use of Medical Provider Network**

(a) The Medical Provider Network (“MPN”) Applicant is responsible for ensuring that each covered employee is informed in writing of the MPN policies under which he or she is covered and when the employee is no longer covered by an MPN. The MPN Applicant shall ensure each covered employee is given written notice of the date of termination or cessation of use of its MPN. The written notice shall be provided to covered employees prior to the effective date of termination or cessation of use of an MPN. The notices required by this section shall be made available in English and Spanish.

(1) The MPN Applicant shall advise every covered employee of the following information in all notices of termination or cessation of use of an MPN by an MPN Applicant or insured employer:

- (A) The effective date of termination or cessation of use of the MPN.
- (B) The insurer's or employer's liability for continuing care for ongoing claims, and the potential penalties that may be imposed by the WCAB for unreasonable delay or interruption of that care.
- (C) The name, address and telephone number of the person to contact with questions concerning the termination or cessation of use, including any questions about continuity of care or transfer of care.
- (D) If there will be a period of no MPN coverage due to a termination, cessation of use, or before a change to a different MPN is effective, then notice shall be given of an employee's rights to a choice of physician under Labor Code section 4600. Specifically, an employee who has an existing industrial illness or injury that is being treated under the MPN shall have the right under Labor Code section 4600 to be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area after 30 days have elapsed from the date the employee notified the employer of his or her injury.
- (E) Any pending Independent Medical Review under that MPN shall also be terminated.

(2) If an MPN Applicant or insured employer is also changing MPN coverage to a different MPN, the MPN Applicant is responsible for ensuring that every covered employee is given notice of the following information in addition to the information required for an MPN termination or cessation of use:

(A) Notice that any injured worker receiving treatment from a provider not in the subsequent MPN, may be entitled to transfer of care to continue treatment with his or her current provider. Transfer of care applies when an employee has an acute, serious chronic or terminal illness or has a prior scheduled medical procedure with the non-MPN provider, pursuant to section 9767.9 of these regulations. The notice shall also advise that an employee may be required to treat within the new MPN after the transfer of care period.

(B) Notice that is required by sections 9767.12(a) and (c) for new MPN coverage and for a change of MPNs.

(b) Notice of termination or cessation of use of an MPN may be combined with the notice of the change to new MPN coverage if the combined notice meets all the MPN regulatory requirements.

(c) Notice of a change of MPNs shall be transmitted by the MPN Applicant providing the new MPN coverage to the Division, not less than 45 calendar days prior to the effective date of the termination or cessation of use of the MPN. A written letter signed by the MPN Applicant's

authorized individual shall be submitted to DWC stating the effective date of the termination or cessation of use of the prior MPN, the planned effective date of the new MPN coverage, and shall attach a copy of the employee notice(s) to be sent to the covered employees pursuant to this section. The notices of a change of MPNs shall not be distributed without approval from DWC. If a notice is timely filed and DWC does not act by the date the notice should be distributed, then the notice shall be deemed approved.

(1) If a change in MPN coverage results in modifications to an MPN's plan application or results in the filing of a new MPN application, the MPN modification or new application filing shall be submitted to DWC pursuant to section 9767.8 or 9767.3, whichever is applicable. Distribution to covered employees of the 30-day notice of a change of MPNs shall occur after DWC's approval of an MPN modification or new MPN.

Authority: Sections 59, 124, 133, 138.3, 138.4, 4616, and 5307.3, Labor Code.

Reference: Section 4616.2, Labor Code.

**Chapter 4.5. Division of Workers' Compensation Subchapter 1. Administrative Director --  
Administrative Rules Article 8.**

**Benefit Notices; Claims Administrator's Duties and Responsibilities; Claim Form and  
Notice of Potential Eligibility for Benefits; Regulatory Authority of the Administrative  
Director.**

**§9810. General Provisions.**

(a) This Article applies to benefit notices prepared on or after its effective date. Amendments to this Article filed with the Secretary of State on December 11, 2007 shall become effective for notices required to be sent on or after April 9, 2008.

(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.

(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 notice letters shall identify the claims administrator's name, mailing address and telephone number, 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 shall clearly state that additional information may be obtained from an Information and Assistance officer with the Division of Workers' Compensation. 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.

(d) Benefit notices, excepting those notices whose language or format are 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 shall make sample notices that comply with these requirements available on the DWC website.

(e) The claims administrator shall provide copies to the employee, upon request, of all medical reports, relevant to any benefit notice issued, or which are not required to be provided along with a notice and have not yet been provided to the employee other than psychiatric reports which the physician has recommended not be provided to the employee.

(f) The claims administrator shall send a copy of each benefit notice, and any enclosures not previously served on the attorney, concurrently to the attorney of any represented employee.

(g) 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, 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.

(h) Copies of all benefit notices sent to injured workers shall be maintained by the claims administrator in the claims file. In lieu of retaining a copy of any attachments to the notice, the claims administrator may identify the attachments by name and revision date on the notice. These copies may be maintained in paper or electronic form.

(i) All benefit notices shall be made available in English and Spanish, as appropriate.

Authority: Sections 59, 124, 133, 138.3, 138.4, 139.5(a)(2), 4061(a), (b), (d) and 5307.3, Labor Code.

Reference: Sections 138.4, 139.5(a)(3), 4061 and 4650(a) through (d), Labor Code.

## §9811. Definitions.

As used in this Article:

- (a) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured, a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority, or an administrator for an alternative dispute resolution (ADR) program established under Labor Code section 3201.5 or 3201.7.
- (b) "Date of knowledge of injury" means the date the employer had knowledge of a worker's injury or claim of injury.
- (c) "Date of knowledge of Injury and disability" means the date the employer had knowledge of (1) a worker's injury or claim of injury, and (2) the worker's inability or claimed inability to work because of the injury.
- (d) "Duration" means any known period of time for which benefits are to be paid, or, where benefits will continue for an unknown period of time the event that will occur which will determine when benefits will terminate.
- (e) "Employee" includes dependent(s) in the event of any injury which results in death.
- (f) "Employee's (or claimant's) remedies", means a statement of the employee's rights of which an employee or claimant shall be informed in benefit notices when specified in these regulations.

Every benefit notice, excepting those mandatory notices set forth in statute or where a specific notice form has been adopted as a regulation, shall include a mandatory statement of employee's (or claimant's) remedies:

For claims not falling under an alternative dispute resolution program (ADR) program under Labor Code sections 3201.5 or 3201.7, the following language shall be used:

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (*insert adjuster's name and telephone number*). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (*insert local I&A number*).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

[http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm)

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

For employees subject to an ADR program under Labor Code sections 3201.5 or 3201.7, the claims administrator may substitute the following language where appropriate:

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (insert adjuster's name and telephone number) or, (insert name of ombudsperson or mediator if employee is subject to an ADR agreement). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster, ombudsperson or mediator. If you want further information on your rights to benefits or disagree with our decision, you may also contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number). Please be sure to inform the Information and Assistance Officer that you are subject to an alternative dispute resolution program.

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

[http://www.dir.ca.gov/DWC/dwc\\_home\\_page.htm](http://www.dir.ca.gov/DWC/dwc_home_page.htm)

**NOTE:** For employees subject to an ADR program under Labor Code section 3201.5, the claims administrator may include the following language if appropriate under the provisions of the ADR program:

In accordance with the (insert union name) agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. Your right to obtain legal advice is not limited and you may obtain such at your own expense at anytime. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.

(g) "Employer" means any person or entity defined as an employer by Labor Code Section 3300.

(h) "Injury" means any injury as defined in Labor Code Section 3208 which results in medical treatment beyond first aid, lost time beyond the date of injury, or death.

(i) “Permanent and stationary status,” means the point when the employee has reached maximal medical improvement, his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment.

Authority: Sections 59, 133, 138.3, 138.4 and 5307.3, Labor Code.

Reference: Sections 138.4, 139.5(c), (d), 3201.5, 3201.7, 3208, 3300, 3351, 3351.5, 3700, 3753, 4635(a), 4650(a) through (d), 4653, 4654, 4700 and 4701, Labor Code; Sections 11651 and 11652, Insurance Code; Sections 2330 and 2332, Civil Code.

## **§9812. Benefit Payment and Notice.**

(a) Temporary Disability Notices. When an injury causes or is claimed to cause temporary disability:

- (1) Notice of First Temporary Disability Indemnity Payment. The first time the claims administrator pays temporary disability indemnity, the claims administrator shall advise the employee of the amount of temporary disability indemnity due, how it was calculated, and the duration and schedule of indemnity payments. The Temporary Disability Notice shall be sent no later than the 14th day after the employer's date of knowledge of injury and disability. A copy of the most recent version of the DWC informative pamphlet "Temporary Disability Fact Sheet" shall be provided with the notice.
- (2) Notice of Delay in Any Temporary Disability Indemnity Payment. If the employee's entitlement to any period of temporary disability indemnity cannot be determined within 14 days of the date of knowledge of injury and disability, the claims administrator shall advise the employee within the 14-day period of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. If the claims administrator cannot make a determination by the date specified in a notice to the injured worker, the claims administrator shall send a subsequent delay notice to the injured worker, not later than the determination date specified in the previous delay notice, notifying the injured worker of the revised date by which the claims administrator now expects the determination to be made.

(A) Where the delay is related to a medical issue, the notice shall advise an unrepresented employee of one of the following options:

- (1.) 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.
- (2.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) Where the delay is related to a medical issue, the notice shall advise a represented employee of one of the following options:

- (1.) For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- (2.) For dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

The additional delay notices shall comply with all requirements for an original delay notice, except that no copy of the DWC informative pamphlet "QME/AME Fact Sheet" need be provided with the notice unless it has been revised since it was last provided.

- (3) Notice of Denial of Any Temporary Disability Indemnity Payment. If the claims administrator denies liability for the payment of any period for which an employee claims temporary disability indemnity, the notice shall advise the employee of the denial and the reasons for it. The notice shall be sent within 14 days after the determination to deny was made.

(A) Where the denial is related to a medical issue, the notice shall advise an unrepresented employee of one of the following options:

- (1.) If the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- (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.
- (3.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall

include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) Where the denial is related to a medical issue, the notice shall advise a represented employee of one of the following options:

- (1.) If the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- (2.) For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- (3.) For dates of injury on or after January 1, 2005 if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the relevant DWC informative pamphlet(s) "TD Fact Sheet," "QME/AME Fact Sheet" and/or "Permanent Disability Fact Sheet" shall be provided at this time.

(b) Notice of Resumed Benefit Payments (TD, SC, PD, VRTD/VRMA). If the payment of temporary disability indemnity, salary continuation, permanent disability indemnity, or vocational rehabilitation temporary disability indemnity or maintenance allowance is resumed after terminating any of these benefits, the claims administrator shall advise the employee of the amount of indemnity due and the duration and schedule of payments. Notice shall be sent within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

(c) Notice of Changed Benefit Rate, Payment Amount or Schedule (TD, SC, PD, VRTD/VRMA). When the claims administrator changes the benefit rate, payment amount or benefit payment schedule for temporary disability indemnity, salary continuation, permanent disability indemnity, or vocational rehabilitation temporary disability indemnity or maintenance allowance, the claims administrator shall advise the employee, as applicable, of the amount of the new benefit rate and the reason the rate is being changed, or of the new benefit payment schedule. Notice shall be given before or with the new payment.

(d) Notice that Benefits Are Ending (TD, SC, PD, VRTD/VRMA). With the last payment of temporary disability indemnity, permanent disability indemnity, salary continuation, or vocational rehabilitation temporary disability indemnity or maintenance allowance, 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 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.

(1) The notice, except a notice that VRMA is ending, shall advise an unrepresented employee one of the following options:

- (A) 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.
- (B) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status or permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(2) The notice, except a notice that VRMA is ending, shall advise a represented employee:

- (A) If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation.
- (B) If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to

Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the relevant DWC informative fact sheet pamphlet(s) "TD Fact Sheet," "QME/AME Fact Sheet" and/or "Permanent Disability Fact Sheet" shall be provided at this time.

(e) Permanent Disability Notices For Injuries That Occurred Prior To 1991:

- (1) Existence and Extent of Permanent Disability is Known. Within 14 days after the claims administrator knows that the injury has caused permanent disability and knows the extent of that disability, the claims administrator shall advise the employee of the amount of the weekly permanent disability indemnity payment, how it was calculated, the duration and frequency of payments, the date payments can be expected to begin and the total amount to be paid.
- (2) Existence of Permanent Disability is Known, Extent is Uncertain. If the claims administrator knows that the injury has caused permanent disability but cannot determine its extent within the 14 days after the last payment of temporary disability indemnity, or within 14 days after knowledge that the employee's injury has resulted in permanent disability if there was no compensable temporary disability, the claims administrator nevertheless shall make timely payment of permanent disability indemnity and shall advise the employee of the amount 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 the amount of permanent disability indemnity to be paid.

The claims administrator shall notify the employee that his or her medical condition will be monitored until the extent of permanent disability can be determined and that the disability payments will be revised at that time if appropriate. Within 14 days after the claims administrator determines the extent of permanent disability indemnity benefits, the claims administrator shall notify the employee as provided by paragraph (1).

- (3) Existence of Permanent Disability is Uncertain. If the existence of permanent disability is uncertain, the claims administrator shall advise the employee within 14 days after the last payment of temporary disability indemnity, or within 14 days of receiving a claim or medical report alleging the existence of permanent disability if the claims administrator paid no temporary disability, that the claims administrator cannot yet determine whether the injury will cause permanent disability. The notice shall specify the reasons for the delay in determination, the need, if any, for additional information required to make a determination, and when the determination is likely to be made. If the claims administrator cannot make a determination by the date it specified in a notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall comply with all requirements for an original delay notice. If the reason for the delay is that the employee's

medical condition is not permanent and stationary, the claims administrator shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time an evaluation will be performed to determine the amount of permanent disability indemnity, if any, due the employee. Within 14 days after the claims administrator determines that permanent disability exists, the claims administrator shall notify the employee of the commencement of permanent disability indemnity payments as provided by paragraph (1) or (2).

- (4) Notice That No Permanent Disability Exists. If the claims administrator alleges that the injury has caused no permanent disability, the claims administrator shall advise the employee within 14 days after.

(f) Permanent Disability Notices for Injuries Occurring in 1991, 1992, 1993.

- (1) Condition Not Permanent and Stationary (P & S), 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 the last payment of temporary disability indemnity, that permanent disability indemnity is or may be payable but that the amount cannot be determined because the employee's medical condition has not yet reached a stationary status. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment or limitations and the need for continuing medical care. The notice shall advise the employee of the estimated date when a determination is likely to be made, and the claimant's remedies. If the claims administrator cannot make a determination of A) permanent and stationary status, B) the existence and extent of permanent impairment or limitations, and C) the need for continuing medical care by the date it specified in a monitoring notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional notice shall comply with all requirements of the original notice.

- (2) Condition Becomes Permanent and Stationary, May Cause Permanent Disability--Notice of Qualified Medical Evaluator (QME) Procedures. Within 5 working days after receiving information indicating that the employee's condition is permanent and stationary and has caused or may have caused permanent disability, the claims administrator shall advise the employee that his or her medical condition is permanent and stationary and of the procedures for evaluating permanent disability and need for continuing medical care.

(A) The notice shall advise an unrepresented employee of one of the following options:

- (1.) 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.
- (2.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent and stationary status and/or need for future medical care and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) The notice shall advise a represented employee:

If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

- (3) Notice of Permanent Disability Indemnity Payment When Injury Causes Permanent Disability. If the claims administrator knows that the employee has sustained permanent disability, whether or not its extent is known and whether or not the employee's medical condition is permanent and stationary, 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, within 14 days after the last payment of temporary disability indemnity, or within 14 days after knowledge that the employee's injury has resulted in permanent disability, whichever is later.

(A) The notice shall advise an unrepresented employee of one of the following options:

- (1.) If the estimate is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

- (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.
- (3.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) The notice shall advise a represented employee of one of the following options:

- (1.) If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
  - (2.) If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation.
  - (3.) If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- (4) Notice That No Permanent Disability Exists. If the claims administrator alleges that the injury has caused no permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable. This notice shall be sent within 14 days after the claims administrator determines that the injury has caused no permanent disability. The notice shall advise the employee of the process to obtain a formal medical evaluation to contest the determination that the employee has no permanent disability. If the basis for the claims administrator's determination is a medical report, a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet," shall be provided with the notice.

(A) The notice shall advise an unrepresented employee of one of the following options:

- (1.) If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

- (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.
- (3.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) The notice shall advise a represented employee of one of the following options:

- (1.) If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- (2.) If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

(g) Permanent Disability Notices for Injuries Occurring on or after January 1, 1994:

- (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 the last payment of temporary disability indemnity, that permanent disability indemnity is or may be payable but that the amount cannot be determined because the employee's medical condition has not yet reached a stationary status. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment or limitations and the need for continuing medical care. The notice shall advise the employee of the estimated date when a determination is likely to be made. If the claims administrator cannot make a determination of A) permanent and stationary status, B) the existence and extent of permanent impairment or limitations, and C) the need for continuing medical care by the date it specified in a monitoring notice to the

injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional notice shall comply with all requirements of the original notice.

- (2) Condition Becomes Permanent and Stationary, Causes Permanent Disability--Notice of QME/AME Procedures. Together with the last payment of temporary disability or within 14 days of knowledge that the injury is permanent and stationary or has caused permanent disability, the claims administrator shall provide notice of the procedures available to obtain a QME or AME evaluation. The claims administrator shall advise the employee of the claims administrator's estimate of the amount of permanent disability indemnity payable, the basis for the estimate, and whether there is need for continuing medical care. A copy of the medical report on which the estimate of permanent disability was based, and a copy of the most recent version of the DWC informative pamphlets, QME/AME Fact Sheet and/or Temporary Disability Fact Sheet, shall be provided with the notice.

(A) The notice shall advise an unrepresented employee of one of the following options:

- (1.) 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.
- (2.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1.

The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

- (B) If the claims administrator is not requesting a rating from the Disability Evaluation Unit, the notice shall also advise the worker that he or she may contact an Information and Assistance Officer to have the treating physician's evaluation reviewed and rated by the Disability Evaluation Unit.
- (C) If the claims administrator has or will be requesting a rating from the Disability Evaluation Unit on the treating physician's evaluation, the notice shall advise the

employee that he or she will be receiving a rating based on the treating physician's evaluation from the Disability Evaluation Unit.

(D) The notice shall advise a represented employee of one of the following options:

- (1.) For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- (2.) For dates of injury on or after January 1, 2005 if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

(3) Notice That No Permanent Disability Exists. If the claims administrator alleges that the injury has caused no 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. A copy of the medical report on which the determination of no permanent disability was based, and a copy of the most recent version of the DWC informative pamphlets, QME/AME Fact Sheet and Permanent Disability Fact Sheet shall be provided with the notice. A copy of the DWC form prescribed by the Administrative Director for requesting assignment of a panel of Qualified Medical Evaluators shall be provided with the notice unless the employee is represented by an attorney.

(A) The notice shall advise an unrepresented employee of one of the following options:

- (1.) If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
- (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.
- (3.) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall also advise of the procedure for requesting the panel and shall be accompanied by the

form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

- (B) If the denial is based upon the treating physician's report, the notice shall also advise the worker 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.
- (C) If the claims administrator requests a rating from the Disability Evaluation Unit on the treating physician's report, the notice shall advise the employee that he or she will be receiving a rating based on the treating physician's evaluation from the Disability Evaluation Unit.
- (D) The notice shall advise a represented employee of one of the following options:
  - (1.) If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.
  - (2.) For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
  - (3.) For dates of injury on or after January 1, 2005 if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
- (4) Notice of Permanent Disability Indemnity Payment When Injury Causes Permanent Disability. If the claims administrator knows that the employee has sustained permanent disability, whether or not its extent is known and whether or not the employee's medical condition is permanent and stationary, 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, within 14 days after the last payment of temporary disability indemnity, or within 14 days after knowledge that the employee's injury has resulted in permanent disability, whichever is later. A copy of the most recent version of the DWC informative pamphlet "Permanent Disability Fact Sheet," shall be provided with the notice.

For injuries occurring on or after January 1, 2005, the claims administrator shall, concurrently with any increased or decreased payment, notify the injured worker of any increase or decrease in the amount of the injured worker's permanent disability payments, pursuant to Labor Code section 4658, subdivision (d) resulting from the employer's offer of regular, modified or alternative work or resulting from the employer's failure to offer or the employer's early termination of, regular, modified or alternative work. The information required by this subdivision shall be given in the appropriate PD payment start notice, PD payment resumption notice or notice of change in rate, payment amount or payment schedule.

(h) Notices to Dependents in Death Cases. In a case of fatal injury which is or is claimed to be compensable under the workers' compensation laws of this state, or involving accrued compensation which was not paid to an injured employee before the employee's death, the claims administrator shall advise the dependent(s) of the status of any benefits to which they may be entitled or which they have claimed as a result of the employee's death. As used in this subsection, "dependent" includes any person who may be or has claimed to be entitled to workers' compensation benefits as the result of an employee's death (including compensation which was accrued and unpaid to an injured worker before his or her death), and also includes the parent or legal guardian of minor dependent children. The claims administrator shall send each dependent a copy of all notices concerning benefits claimed by, or which may be payable to, that dependent, including notices sent to a different dependent if the benefits paid to the different dependent affect the amount payable to the other claimant. If the claims administrator discovers a new dependent after having sent a notice, the claims administrator shall send copies of each prior notice which concerned benefits to which the newly-discovered dependent might be entitled, to that dependent.

- (1) Benefit Payment Schedule. If the claims administrator pays death benefits (including compensation which was accrued and unpaid to an injured worker before his or her death), the claims administrator shall advise each affected dependent of the amount of the death benefit payable to the dependent, how it was calculated, the duration and schedule of payments and other pertinent information. Notice is required within 14 days after the claims administrator's date of knowledge both of the death and of the identity and address of the dependent.
- (2) Notice of Changed Benefit Rate, Amount or Schedule or that Benefits are Ending. If the claims administrator changes the benefit rate, amount or payment schedule, or ends payment, of a death benefit to a dependent, the claims administrator shall advise the affected dependent of the change and the reason for it, or of the new payment schedule. A notice that benefits are ending shall include an accounting of all compensation paid to the

claimant. A notice that payment is ending shall be sent with the last payment unless the decision to end payment was made after that payment; in that case it shall be sent within 14 days of the last payment. Other notices concerning changed payments shall be sent before or with the changed payment, but not later than 14 days after the last payment which was made before the change.

- (3) Delay in Determining Benefits. If the claims administrator cannot determine entitlement to some or all death benefits, the claims administrator shall advise each affected dependent of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. Notice is required within 14 days after the claims administrator's date of knowledge of the death, the identity and address of the affected dependent, and the nature of the benefit claimed or which might be due. If the claims administrator cannot make a determination by the date it specified in a notice to the affected dependent(s), the claims administrator shall send a subsequent notice to the affected dependent(s), not later than the determination date specified in the previous notice, notifying the affected dependent(s) of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall comply with all requirements for an original delay notice.
- (4) Notices Denying Death Benefits. If the claims administrator denies liability for the payment of any or all death benefits, the claims administrator shall advise the affected dependent(s) of the denial and the reasons for it. The notice shall be sent within 14 days after the determination to deny was made.

(i) Notice Denying Liability for All Compensation Benefits. If the claims administrator denies liability for the payment of all workers' compensation benefits for any claim except a claim for death benefits, including medical-only claims, the claims administrator shall advise the employee of the denial and the reasons for it. The notice shall be sent no later than 14 days after the determination to deny was made. A copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

For claims reported on or after April 19, 2004, if an injured worker has filed a completed claim form with the employer, the claims administrator shall advise the injured worker to send for consideration of payment, all bills for medical services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected, unless he or she has done so already. The claims administrator shall also advise the employee that the maximum payment for medical services that were provided consistent with the applicable treatment guidelines is \$10,000.

A copy of the Notice Denying Liability for All Compensation Benefits shall be served on all lien claimants or all persons or entities who can reasonably be identified by the claims administrator from information in the claims file to be potential lien claimants on account of their having furnished benefits, goods or services for which a lien may be filed under Labor Code sections 4903 through 4906, inclusive.

(j) Notice of Delay in Determining All Liability. If the claims administrator cannot determine whether the employer has any liability for an injury, other than an injury causing death, within 14 days of the date of knowledge of injury, the claims administrator shall advise the employee within the 14-day period of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. If the claims administrator cannot make a determination by the date it specified in a notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall comply with all requirements for an original delay notice. Where the delay is related to a medical issue, a copy of the most recent version of the DWC informative pamphlet “QME/AME Fact Sheet” shall be provided with the notice.

(1) For injuries on or after January 1, 1990, if the claims administrator sends a notice of a delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that the claim is presumed to be compensable if not denied within 90 days from the filing of the claim form, and that this presumption can be rebutted only with evidence discovered after the 90-day period.

(2) For claims reported on or after April 19, 2004, regardless of the date of injury, if the claims administrator sends a notice of delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that Labor Code section 5402(c), provides that within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, for the alleged injury and shall continue to provide treatment until the date that liability is rejected. The notice shall advise the injured worker that the employer’s liability for medical treatment under this Labor Code section is limited to ten thousand dollars (\$10,000).

Authority: Sections 59, 133, 138.3, 138.4, 139.5(a)(2), 4636(d), 4637 and 5307.3, Labor Code.

Reference: Sections 138.4, 139.5, 4061(a), (b), (d)(e)(f), 4062.1, 4650(a) through (d), 4658(d) 4661.5, 4700, 4701, 4702, 4703, 4703.5, 4903 through 4906 and 5402, Labor Code.

### **§9813. Vocational Rehabilitation Notices.**

(a) The following notices are applicable to dates of injury through December 31, 2003. This section shall not apply to dates of injury on or after January 1, 2004.

- (1) Notice of First Payment. The first time the claims administrator pays vocational rehabilitation temporary disability or maintenance allowance, the claims administrator shall advise the employee of the amount of indemnity due, how it was calculated, and the duration and schedule of indemnity payments. The notice is due by the 14th day after the employee requested vocational rehabilitation services. The notice shall include, if applicable, the employee's option to add an amount from permanent disability benefits to increase the maintenance allowance payments to the temporary disability rate.
- (2) Delay in Providing Vocational Rehabilitation. If upon receipt of a medical report which indicates that an employee is likely to be precluded from his or her usual and customary occupation, or upon receipt of a request for vocational rehabilitation services the claims administrator cannot determine the employee's entitlement to vocational rehabilitation services, a notice of delay shall be sent. The notice shall be sent no later than 10 days from the date of receipt of the medical report or no later than 10 days from receipt of the employee's request for services.

The delay notice shall explain the reason for delay, the need, if any, for additional information required to make a determination and the date by which a determination is likely to be made. If the claims administrator cannot make a determination by the date it specified in a notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall include the employee's remedies and shall comply with all requirements for an original delay notice.

- (3) Denial of Vocational Rehabilitation Benefits. The claims administrator shall advise the employee of its determination that an employee is not a qualified injured worker, the reasons for it, enclosed a copy of the document in which the determination is based and the employee's remedies. The notice shall include a DWC Form RU 103 Request for Dispute Resolution. The notice is due within 10 days of either:
  - (A) A request for vocational rehabilitation services; or
  - (B) Receipt of a treating physician's final report determining medical eligibility subsequent to 90 days of aggregate total temporary disability; or
  - (C) Receipt of the document upon which the claims administrator relied for its determination.

If the claims administrator denies liability for rehabilitation services but remains liable for paying VRTD or VRMA benefits, the notice shall explain the distinction between the terminated and continuing rehabilitation benefits.

If the denial is on the basis that the employee is not medically eligible, a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided to the employee.

- (4) Interruption or Deferral of Vocational Rehabilitation Services. Within 10 days after agreeing to interrupt or defer vocational rehabilitation services, the claims administrator shall advise the employee of the interruption and the dates it will be in effect. The claims administrator shall send a like notice within 10 days after agreeing to a new or extended period of interruption. The notice shall include an explanation of the specific steps he or she must take to notify the claims administrator that he or she is ready to resume participation (e.g., written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative), and information regarding the likely termination of the employee's rights to vocational rehabilitation should the employee fail to request services within 5 years from the date of injury.

If the parties agree to an interruption or deferral which extends beyond the statutory period, the notice shall advise the employee that failure to request services within the agreed upon time frame is likely to terminate the employee's rights to rehabilitation services.

For injuries occurring on or after 1/1/94 where an interruption occurs during a vocational rehabilitation plan, the notice shall explain that the plan must by law be completed within 18 months of approval.

(b) Vocational Rehabilitation Notices for Injuries Occurring Prior to 1990.

- (1) Potential Eligibility for Rehabilitation. Within 10 days of receipt of a physician's report or knowledge of a physician's opinion indicating that an employee may be permanently precluded from his or her usual and customary occupation or the position in which he or she was engaged at the time of injury, or if the employee has been totally temporarily disabled for an aggregate of 180 days, the claims administrator shall notify the employee within 10 days of the 180th day of his or her potential eligibility for vocational rehabilitation services. The notice shall include all of the following information:

- (A) An explanation of the vocational rehabilitation services and rehabilitation temporary disability benefits available to the employee;
- (B) Instructions how the employee may apply for vocational rehabilitation (e.g., by written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative);

- (C) Notice of the employee's right to participate in selecting an agreed rehabilitation counselor;
- (D) Notice that vocational rehabilitation benefits may not be settled or otherwise converted to cash payments;
- (E) Either an offer of vocational rehabilitation services, or notice of delay or denial notice in accordance with Section 9813(a)(2) or (3).

(c) Vocational Rehabilitation Notices for Injuries Occurring in 1990, 1991, 1992 or 1993.

- (1) At 90 days of Aggregate Temporary Disability Benefits. The claims administrator shall notify the worker no later than 10 days after an employee has accrued 90 days of aggregate temporary total disability benefits of the assignment of the Qualified Rehabilitation Representative (QRR) for the purpose of explaining the employee's potential entitlement to vocational rehabilitation services. The notice shall include a statement that the QRR will be assisting the employee in the development of a job description to submit to the treating physician for an opinion regarding whether the employee may be released to his or her usual and customary occupation. The notice shall further state that the employee will be notified of the physician's opinion when available.
- (2) Potential Eligibility for Rehabilitation. Within 10 days of receipt of a physician's report or knowledge of a physician's opinion indicating that an employee is medically eligible for vocational rehabilitation, or if prior notice has not been sent, within 10 days after the employee has been totally temporarily disabled for an aggregate of more than 365 days, the claims administrator shall notify the employee of his or her potential eligibility for vocational rehabilitation services. The notice shall include the following information:
  - (A) The "Help in Returning to Work" pamphlet published by the Division of Workers' Compensation;
  - (B) If the notice contains an offer of services, the notice shall include instructions on how to apply for vocational rehabilitation services (e.g., by written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative);
  - (C) If the notice contains an offer of services, the notice shall state that failure to apply within 90 days of receipt of this notice may terminate the employee's entitlement to vocational rehabilitation services;
  - (D) If the notice contains an offer of services, information on the employee's right to assist in the selection of an agreed upon Qualified Rehabilitation Representative;
  - (E) If the notice contains an offer of services, advice that the employee may request an evaluation of his or her ability to benefit from the provision of services prior to accepting or rejecting vocational rehabilitation services;

(F) The notice may include a statement from the claims administrator that every effort will be made to identify a modified or alternate job with the same employer to speed the employee's return to the labor market.

(G) Either an offer of vocational rehabilitation services, or a delay or denial notice in accordance with Section 9813(a)(2) or (3) of these regulations.

(3) **Reminder of Potential Eligibility.** If the employee has not requested vocational rehabilitation services after notification of medical eligibility, the claims administrator shall remind the employee of his or her right to vocational rehabilitation services. The notice shall be made not earlier than 45 nor later than 70 days after the employee's receipt of the Notice of Potential Eligibility.

(4) **Intention to Withhold Maintenance Allowance for Failure to Cooperate.** If the employee unreasonably fails to cooperate in the provision of vocational rehabilitation services, the claims administrator shall give the employee written notice of any intention to withhold payment of vocational rehabilitation maintenance allowance, the reasons, and the employee's right to object within 10 days of receiving the notice. The notice shall be made at least 15 days before ending payment of vocational rehabilitation maintenance allowance. The notice shall include a DWC Form RU 103 "Request for Dispute Resolution".

(d) **Vocational Rehabilitation Notices for Injuries Occurring on or after January 1, 1994 and before January 1, 2004.**

(1) **At 90 days of Aggregate Temporary Disability Benefits.** The claims administrator shall notify the employee no later than 10 days after the employee accrues 90 days of aggregate temporary total disability benefits of the employee's potential rights to vocational rehabilitation. The notice shall include the "Help in Returning to Work" pamphlet as set forth in section 10133.2 of these regulations;

(2) **Potential Eligibility for Rehabilitation.** Within 10 days of receipt of a physician's report or knowledge of a physician's opinion indicating that an employee is medically eligible for vocational rehabilitation, or if prior notice has not been sent within 10 days after the employee has been totally temporarily disabled for an aggregate of 365 days, the claims administrator shall notify the employee of his or her potential eligibility for vocational rehabilitation services. The notice shall indicate the following information:

(A) The "Help in Returning to Work" pamphlet as set forth in section 10133.2 of these regulations;

(B) If the notice contains an offer of services, the notice shall include instructions on how to apply for vocational rehabilitation services (e.g., by written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative);

- (C) If the notice contains an offer of services, the notice shall state that failure to apply within 90 days of receipt of this notice may terminate the employee's entitlement to vocational rehabilitation services;
  - (D) If the notice contains an offer of services, information on the employee's right to assist in the selection of an agreed upon Qualified Rehabilitation Representative;
  - (E) If the notice contains an offer of services, advice that the employee may request an evaluation of their ability to benefit from the provision of services prior to accepting or rejecting vocational rehabilitation services. The employee must further be advised that fees for such an evaluation are included within the forty-five hundred dollars (\$4,500) maximum fees available for counseling services.
  - (F) The notice shall include a statement from the claims administrator whether a modified or alternate job with the employer is available. In the event that additional investigation into the availability of alternate or modified work is required, a final notice regarding the availability of modified or alternate work shall be sent within 30 days. This time limit may be extended by agreement of the parties.
  - (G) Either an offer of vocational rehabilitation services, or delay or denial notice in accordance with paragraph (2) or (3) of subdivision (a).
- (3) **Reminder of Potential Eligibility.** If the employee has not requested vocational rehabilitation services after notification of medical eligibility, the claims administrator shall remind the employee of his or her right to vocational rehabilitation services. The notice shall be made not earlier than 45 nor later than 70 days after the employee's receipt of the Notice of Potential Eligibility.
- (4) **Intention to Withhold Maintenance Allowance for Failure to Cooperate.** If the employee unreasonably fails to cooperate in the provision of vocational rehabilitation services, the claims administrator shall give the employee written notice of any intention to withhold payment of vocational rehabilitation maintenance allowance, the reasons, and the employee's right to object within 10 days of receiving the notice. The notice shall be made at least 15 days before ending payment of vocational rehabilitation maintenance allowance. The Notice shall include a DWC Form RU 103 "Request for Dispute Resolution".

Authority: Sections 59, 133, 138.3, 138.4, 139.5(a)(2), 4636(d), 4637 and 5307.3, Labor Code.

Reference: Sections 138.4, 139.5, 4061(a), (b), (d), 4636, 4637, 4641, 4643, 4644, 4650(a) through (d), 4661.5, 4700, 4701, 4702, 4703, 4703.5, 4903(a) and 5402, Labor Code.

**§9813.1. Notice of Supplemental Job Displacement Benefit, Notice of Offer of Modified or Alternative Work. For Injuries Occurring on or after January 1, 2004.**

(a) Notice of Potential Right to Supplemental Job Displacement Benefit (SJDB). Within 10 days of the last payment of temporary disability indemnity, if such notice has not previously been provided, the claims administrator shall advise the employee of his or her potential right to the supplemental job displacement benefit. The claims administrator shall use the mandatory form "Notice of Potential Right to Supplemental Job Displacement Benefit" that is set forth in section 10133.52 of these regulations. The notice shall be sent to the employee by certified mail.

(b) Notice of Offer of Modified or Alternative Work. Within 30 days of the termination of temporary disability indemnity payments, the employer may offer, in the form and manner prescribed by section 10133.53 of these regulations, modified or alternative work accommodating the employee's work restrictions, lasting at least 12 months.

Authority: Sections 59, 133, 138.3, 138.4, 4658.5, 5307.3, Labor Code.

Reference: Sections 124, 4658.1, 4658.5, and 4658.6, Labor Code.

**§9813.2 Return to Work Notices. For injuries occurring on or after January 1, 2005.**

Notice of Offer of Regular Work, Notice of Offer of Modified or Alternative Work. Within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary:

(a) If an employer does not serve the employee with a notice of offer of regular work, modified work or alternative work as set forth in section 10002, each payment of permanent partial disability remaining to be paid to the employee from the date of the end of the 60 day period shall be paid in accordance with Labor Code section 4658 (d)(1) and increased by 15 percent.

(b) If an employer serves the employee with a notice of offer of regular work, modified work or alternative work as set forth in section 10002(b)(3) and (4), each payment of permanent partial disability remaining to be paid from the date the offer was served on the employee shall be paid in accordance with Labor Code section 4658 (d)(1) and decreased by 15 percent, regardless of whether the employee accepts or rejects the offer.

(c) The employer shall use Form DWC-AD 10133.53 (Section 10133.53) to offer modified or alternative work, or Form DWC-AD 10003 (Section 10003) to offer regular work. The claims administrator may serve the offer of work on behalf of the employer.

Authority: Sections 59, 133, 138.3, 138.4, 4658, 5307.3, Labor Code.

Reference: Sections 124, 4658, and 4658.1, Labor Code.