

BASICS FOR INJURED WORKER: NAVIGATING CALIFORNIA WORKERS COMPENSATION

Q. What is workers' compensation?

A. If you get hurt or sick because of work, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work, such as hurting your back in a fall, getting burned by a chemical that splashes on your skin or getting hurt in a car accident while making deliveries.

--or--

Repeated exposures at work, such as hurting your wrist from doing the same motion over and over or losing your hearing because of constant loud noise.

Q. What are the benefits?

A. Workers' comp insurance provides six basic benefits:

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work
- **Temporary disability benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering
- **Permanent disability benefits:** Payments if you don't recover completely
- **Supplemental job displacement benefits (if your date of injury is in 2004 or later):** Vouchers to help pay for retraining or skill enhancement if you don't recover completely and don't return to work for your employer
- **Vocational rehabilitation (if your date of injury is before 2004):** Job placement counseling and possibly retraining if you are unable to return to your old job and your employer doesn't offer other work
- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness.

Q. How can I avoid getting hurt on the job?

A. Employers in California are required to have an injury and illness prevention program. The program must include worker training, workplace inspections, and procedures for correcting unsafe conditions promptly. Learn about and participate in your employer's program and report unsafe conditions to your employer. If they don't respond, call [Cal/OSHA](#), the state agency that enforces health and safety laws.

Q. What should I do if I have a job injury?

A. First, report the injury to your employer by telling your supervisor right away. If your injury or illness developed over time, report it as soon as you learn or believe it was caused by your job.

Reporting promptly helps prevent problems and delays in receiving benefits, including medical care you may need. If your employer does not learn about your injury within 30 days and this prevents your employer from fully investigating the injury and how you were injured, you could lose your right to receive workers' compensation benefits.



Next, get emergency treatment if you need it. Your employer may tell you where to go for treatment. Tell the health care provider who treats you that your injury or illness is job-related.

Then, fill out a claim form, called a [DWC form 1](#), and give it to your employer. Your employer must give or mail you a claim form within one working day after learning about your injury or illness. If your employer doesn't give you the claim form you can download it from the [forms page](#) of the DWC Web site.

MEDICAL CARE WITHIN THE WORKERS COMPENSATION SYSTEM

Q. What kind of medical care will I receive for my injury?

A. The state Division of Workers' Compensation (DWC) is adopting medical treatment guidelines regarding the kinds and amount of treatment needed for different job injuries. State law requires the guidelines to be "scientifically based, nationally recognized, and peer-reviewed." They will be considered correct in most cases. In the meantime, guidelines published by the American College of Occupational and Environmental Medicine (ACOEM), called "Occupational Medicine Practice Guidelines," are considered correct in most cases. If your injury is not covered by the ACOEM guidelines, treatment may follow other guidelines that are scientifically based and nationally recognized.

Q. Do these guidelines apply if my case is already settled?

A. They may. Treatment guidelines are considered correct even in cases that settled before the guidelines were added to workers' compensation law in 2003. Your claims administrator may continue to pay for medical care you're accustomed to for your injury. If you have a question about whether you should still be receiving a certain kind of medical treatment and you can't work it out with your claims administrator, call your [local information & assistance officer](#) for guidance.

If your medical treatment has been denied you can request an expedited hearing before a workers' compensation administrative law judge to get the situation resolved. Contact the [information & assistance officer](#) at your [local DWC office](#) for help.

Q. The claims administrator hasn't accepted or denied my claim yet, but I need medical care for my injury now. What can I do?

A. The claims administrator is required to authorize medical treatment within one working day after you file a claim form with your employer, even while your claim is being investigated. This treatment is limited to \$10,000. If the claims administrator does not authorize treatment right away, speak with your supervisor, someone else in management or the claims administrator about the law requiring immediate medical treatment. Ask for treatment to be authorized now, while waiting for a decision on your claim.

Q. Are there limits on certain kinds of treatment?

A. Yes. If your date of injury is in 2004 or later, you are limited to a total of 24 chiropractic visits, 24 physical therapy visits, and 24 occupational therapy visits, unless the claims administrator authorizes additional visits.

Q. How long can I continue to receive treatment?

A. For as long as it's medically necessary. However, some treatments are limited by law and the medical treatment you receive must be evidence-based.



The state of California is currently using the "American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, Second Edition" as the standard or evidence-based medicine. The guidelines lay out treatments scientifically proven to cure or relieve work-related injuries and illnesses. They also deal with how often the treatment is given and for how long, among other things.

If the treatment your doctor wants to provide goes beyond what is recommended by the ACOEM guidelines, your doctor must use other evidence to show the treatment is necessary and will be effective.

Additionally, your doctor's treatment plan may be reviewed by a third party hired by the claims administrator. This process is called utilization review (UR). All claims administrators are required by law to have a UR program. They use UR to decide whether or not to approve treatment recommended by your doctor.

Q. Can I hear more about utilization review?

A. Utilization review (UR) is the program claims administrators use to make sure the treatment you receive is medically necessary. All claims administrators are required by law to have a utilization review program. This program will be used to decide whether or not to approve medical treatment recommended by your doctor. See the DWC's [fact sheet on UR](#) for more details.

The state has [rules](#) about how UR must be conducted. If you believe the UR company reviewing your doctor's plan is not following those rules you can [file a complaint](#) with the Division of Workers' Compensation.

Also, if there is a dispute over your medical care you have the right to be seen on an expedited basis by a workers' compensation administrative law judge who can resolve the dispute. See Information & Assistance Unit [guide 6](#) for information and the form needed to request an expedited hearing.

Q. What happens if I got treated and the claims administrator won't pay for it? Do I have to pay?

A. Most likely, no. This is a problem your doctor and the claims administrator need to work out.

Q. What are medical provider networks?

A. A [medical provider network \(MPN\)](#) is a group of health care providers set up by your employer's insurance company and approved by DWC's administrative director to treat workers injured on the job. Each MPN includes a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. If your employer is in an MPN your workers' compensation medical needs will be taken care of by doctors in the network unless you were eligible to pre-designate your personal doctor and did so before your injury happened.

Q. What does pre-designating a personal doctor involve?

A. This is a process you can use to tell your employer you want your personal physician to treat you for a work injury. You can pre-designate your personal doctor of medicine (M.D.) or doctor of osteopathy (D.O.) only if: your employer offers group health coverage; the doctor has treated you in the past and has your medical records; prior to the injury the doctor agreed to treat you for work injuries or illnesses and; prior to the injury you provided your employer the following in writing: (1) Notice that you want your personal doctor to treat you for a work-related injury or illness and (2) Your personal doctor's name and business address.



The DWC has a form for pre-designating a personal physician on the [forms page of its Web site](#).

Q. What if I don't like the MPN doctor?

A. You have unlimited choice of doctors within the network so you can switch to a different doctor. The claims administrator is required to give you a list of doctors in your MPN so this should solve the problem.

Q. What if I disagree with the MPN doctor's diagnosis or treatment plan?

A. There are two tracks for resolving a medical dispute if you're in an MPN, depending on the situation. If your MPN doctor requests treatment that you agree with and that treatment gets denied under utilization review (UR), you have the right to be evaluated by a qualified medical evaluator (QME). The claims administrator must advise you of this right. However, if you disagree with your MPN doctor about your diagnosis or treatment, you do NOT go to a QME - you have other options. First, you can change to another physician on the MPN list. You can also ask for a 2nd and 3rd opinion from a different MPN doctor. If you still disagree, you can have an independent medical review (IMR) to resolve the dispute. See the information on your MPN provided by your employer.

Q. Who decides what type of work I can do while recovering?

A. Your treating doctor is responsible for explaining in a medical report:

- The kind of work you can and can't do while recovering
- The changes needed in your work schedule or assignments.

You, your treating doctor, your employer and your attorney (if you have one) should review your job description and discuss the changes needed in your job. For example, your employer might give you a reduced work schedule or have you spend less time on certain tasks.

If you disagree with your treating doctor, you must promptly write to the claims administrator about the disagreement or you may lose important rights.

Q. What if either the claims administrator or I disagree with my doctor's treatment plan or other medical issues?

A. You will be asked to see another doctor for a second opinion. This doctor will either be a qualified medical evaluator (QME) or, if you have an attorney, it could be an agreed medical examiner (AME). This doctor will examine you and write a report giving his or her opinion. If you and the claims administrator can't resolve your disagreement after you see the QME or AME, you may need to take your case to the Workers' Compensation Appeals Board (WCAB). The reports of your treating physician and the QME or AME can be used by a workers' compensation administrative law judge to decide what medical treatment should be provided to you.

NOTE: If you're in an MPN, see answer to above question on disagreeing with the MPN doctor's diagnosis or treatment plan.

Q. I don't get this whole QME process. Why do I need to see a QME?

A. You and/or the claims administrator might disagree with what the treating doctor says. There could be other disagreements over medical issues in your claim. A doctor has to address those disagreements. You might disagree over:

- Whether or not your injury was caused by your work
- Whether or not you need treatment for your injury
- What type of treatment is appropriate
- Whether or not you need to stay home from work to recover
- A permanent disability rating.

The QME (or AME if you're represented by an attorney) report will help determine what benefits you receive. See the DWC's [fact sheet on QMEs and AMEs](#) for more information.

Q. The workers' comp system seems very confusing. Should I get an attorney?

A. That's a question you have to answer for yourself. You're not required to have an attorney, even if you have a disagreement with the claims administrator. However, if your case is complex you may benefit from having one. If you decide not to get an attorney, the [information & assistance \(I&A\) officer](#) at your local DWC office can help you with your claim. Even if you decide to hire an attorney you should educate yourself about your rights and responsibilities, stay in communication with your employer and claims administrator and don't be afraid to ask them questions. The vast majority of workers' compensation claims are resolved between injured workers and claims administrators with no problems.

Q. I'm having a problem getting my benefits. What resources are available to me?

A. Your local [I&A officers](#) are a great resource and their services are free. They are not there to act on your behalf as an attorney would, but they'll help you understand how to act on your own behalf.

Attend a [free seminar for injured workers](#) at a local DWC office for a full explanation of workers' comp benefits, your rights and responsibilities. You can also make an appointment with an I&A officer and speak to them privately at your convenience.

You can also find a lot of information on the [I&A page of the DWC's Web site](#). Check out the fact sheets and guides for injured workers. The fact sheets provide answers to frequently asked questions about issues affecting your benefits. The guides will help you fill out forms you may need to get a problem with your claim resolved at the local DWC office.

Q. I'm disabled and need assistance in order to use DWC services. Is there any help available?

A. Yes. Disability accommodations can be provided for individuals using all DWC services and programs, including services you might need for a hearing at the workers' comp court or other services provided by the Rehabilitation Unit, the Information and Assistance Unit or the Disability Evaluation Unit.

[Click here](#) for more information on receiving an Americans with Disabilities Act (ADA) accommodation.

Q. Besides workers' compensation benefits, can I get any other financial assistance?

A. Other benefits may be available. These include:

- Benefits paid by the state and federal governments such as [State Disability Insurance \(SDI\)](#), [unemployment insurance](#), and [Social Security Disability Insurance \(SSDI\)](#) payments
- Benefits offered by employers and unions, such as sick leave, group health insurance, long term disability (LTD) and salary continuation plans
- Payments if your injury was caused by someone other than your employer.

Q. How do I find out what's going on with my case?

A. If you have an attorney, he or she should be keeping you up to date. If you don't have an attorney, contact the I&A officer at [your local office](#) for a status report. The DWC also has a call center through which many calls to local offices are routed. The call center staff is also fully equipped to give you status updates on your case.

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TEMPORARY DISABILITY BENEFITS

Q. What are temporary disability benefits?

A. Temporary disability (TD) benefits are payments you get if you lose wages because your injury prevents you from doing your usual job while recovering. See the DWC [fact sheet on TD](#) for more information.

Q. Are there different types of temporary disability benefits?

A. There are two types of temporary disability benefits. If you cannot work at all while recovering, you receive temporary total disability (TTD) benefits. If you can do some work while recovering, you receive temporary partial disability benefit (TPD) payments.

Q. How much will I receive in temporary disability payments?

A. As a general rule, temporary disability pays two-thirds of the gross (pre-tax) wages you lose while you are recovering from a job injury. However, you cannot receive more than the maximum weekly amount set by law, which is \$840 for 2006. Beginning Jan. 1, 2007, the maximum goes up to \$881.66. Your wages are figured out by using all forms of income you receive from work: wages, food, lodging, tips, commissions, overtime and bonuses. Wages can also include earnings from work you did at other jobs at the time you were injured. Give proof of these earnings to the claims administrator. The claims administrator will consider all forms of income when calculating your temporary disability benefits.

Q. How are the minimum and maximum temporary disability amounts determined?

A. Beginning Jan. 1, 2006, the minimum and maximum rates are adjusted annually to the greater of \$840 or the state average weekly wage (SAWW). The SAWW for the 12 months ending Mar. 31, 2005 was \$838.42, so maximum TTD and PTD rates for 2006 work injuries remained \$840 -- the same as for 2005 injuries. The 4.96 percent increase in the SAWW for the 12 months ending Mar. 31, 2006 means the rate rises to \$881.66 for injuries on or after Jan. 1, 2007. The minimum TTD rate is also subject to annual adjustment based on increases in the SAWW, so the minimum rate of \$126.00 will increase to \$132.25.

Q. What about temporary total disability payments for low-wage workers?



A. For injuries occurring on or after Jan. 1, 2003, the minimum TTD rate is \$126 per week, regardless of earnings. Any employee with earnings of less than \$189 per week is entitled to the minimum TTD rate of \$126. If earnings are more than \$189 per week, TTD payments will be paid at two-thirds the injured worker's wages.

Effective Jan. 1, 2007 the minimum TTD rate will go to \$132.25 per week based on the SAWW. Any employee with earnings below \$198.38 will be entitled to the new minimum TTD rate for injuries on or after Jan. 1, 2007.

The minimum TTD will continue to be re-calculated each January 1 based on changes to the SAWW.

Q. When does temporary disability start and stop?

A. TD payments begin when your doctor says you can't do your usual work for more than three days or you get hospitalized overnight. Payments must be made every two weeks. Generally, TD stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to. If you were injured after Apr. 19, 2004, your TD payments won't last more than 104 weeks from the first payment for most injuries. Payments for a few long-term injuries such as severe burns or chronic lung disease can go longer than 104 weeks. TD payments for these injuries can continue for up to 240 weeks of payment within a five-year period.

You can also file a [state disability insurance \(SDI\)](#) claim with the Employment Development Department. You should file this claim even if your workers' comp case is accepted. This will allow you to get SDI payments after the 104 weeks of TD payments if you are still too sick or hurt to go back to work.

Q. Are temporary disability benefits taxable?

A. No. You don't pay federal, state or local income tax on TD benefits. Also you don't pay Social Security, taxes, union dues or retirement fund contributions.

Q. Can my first temporary disability payment be delayed?

A. Sometimes. If the claims administrator can't determine whether your injury is covered by workers' compensation, he or she may delay your first TD payment while investigating. A delay is usually not longer than 90 days. If there is a delay, the claims administrator must send you a delay letter. It must explain why you won't receive payments, what additional information the claim administrator needs and when a decision will be made. If there are further delays, the claims administrator must send you additional delay letters.

If the claims administrator doesn't send you a letter denying your claim within 90 days after you filed the claim form, your claim is considered accepted in most cases.

Q. Is the claims administrator required to pay a penalty for delays in temporary disability payments?

A. It depends. If the claims administrator sends a payment late, he or she must pay you an additional 10 percent of the payment on a self-assessed basis. This is true even if there is a reasonable excuse for the delay. You could be awarded a substantial extra payment if there was no reasonable excuse for the delay. However, there's no penalty if the claims administrator sends you a delay letter as explained above.

Q. Why am I receiving so many letters?

A. The claims administrator must keep you up to date by sending letters that explain how payments were determined, why TD will be delayed, reasons for changing TD payment amounts and why the TD benefits are ending.

Q. My temporary disability payments stopped without explanation. What should I do?

A. Talk to your employer or claims administrator. If that doesn't help, contact your [local DWC information & assistance officer](#).

PERMANENT DISABILITY BENEFITS

Q. What are permanent disability benefits?

A. Most workers fully recover from job injuries but some continue to have medical problems. Permanent disability is any lasting disability that results in a reduced earning capacity after maximum medical improvement is reached. If your injury or illness results in permanent disability you are entitled to permanent disability (PD) benefits, even if you are able to go back to work.

PD benefits are limited. If you lose income, PD benefits may not cover all the income lost. If you experience losses unrelated to your ability to work, PD benefits will not cover those losses. See the DWC [fact sheet on PD](#) for more information.

Q. How is permanent disability identified?

A. A doctor determines if your injury or illness caused permanent disability. After your doctor decides your injury or illness has stabilized and no change is likely, permanent disability is evaluated. At that time, your condition has become [permanent and stationary \(P&S\)](#). Your doctor might use the term [maximal medical improvement \(MMI\)](#) instead of P&S.

Once you are P&S or have reached MMI, your doctor will send a report to the claims administrator telling them you have PD. The doctor also determines if any of your disability was caused by something other than your work injury. For example, a previous injury or other condition. This is called apportionment.

Q. What happens to the doctor's report?

A. If you don't have an attorney the doctor's report is sent to the claims administrator and to the DWC's [Disability Evaluation Unit \(DEU\)](#). A rater from the DEU will use the doctor's report to calculate your PD rating. If you have an attorney the rating can be done by either the DEU or a private rater.

The process used to calculate your rating can vary depending on your date of injury and other factors. The PD rating determines the benefits you'll receive.

You have a right to receive a copy of the doctor's report and can request copies of all medical reports. Read the doctor's report carefully, make sure it's complete and see if you agree with the doctor's conclusions. Information left out could result in loss of some benefits.

Q. What if I don't agree with the doctor?

A. If you or the claims administrator disagrees with your doctor's findings you can be seen by a doctor called a qualified medical evaluator (QME). You request a QME list (called a panel) from the [DWC Medical Unit](#). The claims administrator will send you the forms to request a QME. Your employer will pay for the cost of the QME exam. You have 10 days from the date the claims administrator tells you to begin the QME process to submit your request form to the [DWC Medical Unit](#). If you do not submit the form within 10 days, the claims administrator will do it for you and will get to choose the kind of doctor you'll see.

There are other specific and strict timelines you must meet in filing your QME forms or you will lose important rights.

When you receive the list of QMEs from the DWC Medical Unit you have to select a doctor, set up an exam and tell the claims administrator about your appointment. If you do not make the appointment within 10 days, the claims administrator may pick the doctor and make the appointment for you.

If you have an attorney, he or she can help you pick a QME or you can be evaluated by an agreed medical evaluator (AME). An AME is the doctor your attorney and the claims administrator agree on to do your medical examination. In this case you should discuss your options with your attorney.

Q. Can I get more detail about the PD rating and how is it calculated?

A. After your examination the doctor will write a medical report about your impairment. Impairment means how your injury affects your ability to do normal life activities. The report includes whether any portion of your disability was caused by something other than your work injury. The doctor's report ends with an impairment number.

Next, the impairment number is put into a formula to calculate your percentage of disability. Disability means how the impairment affects your ability to work. Your occupation and age at the time of your injury and your future earning capacity are all also included in the calculation.

Then, any portion of your disability caused by something other than your work injury is taken out of the calculation.

Your disability will then be stated as a percentage. Your percentage of disability equals a specific dollar amount, depending on the date of your injury and your average weekly wages at the time of injury. A rating specialist from the DWC [Disability Evaluation Unit](#) (DEU) may help calculate your rating.

If you were injured on or after Jan. 1, 2005 your PD award may be increased or decreased by 15 percent, depending on whether you work for an employer with 50 or more employees and your employer offers -- and you accept or decline -- [regular](#), [alternative](#) or [modified work](#).

Q. I don't agree with the rating by the state disability rater. What can I do?

A. If you don't have an attorney, you can ask the state Division of Workers' Compensation (DWC) to review the rating. The DWC will determine if mistakes were made in the medical evaluation process or the rating process. This is called reconsideration of your rating. . You can also present your case to a workers' compensation administrative law judge. Contact a state [I&A officer](#) for help. Workers with attorneys cannot request reconsideration. If you have an attorney, he or she can present your case to a judge.

Q. How much will I be paid for my permanent disability?

A. PD benefits are set by law. The claims administrator will determine how much to pay you based on three factors:

- Your disability rating (expressed as a percentage)
- Date of injury
- Your wages before you were injured.

The maximum weekly amount you can receive, based on those factors:

	2003	2004	2005	2006	2007	2008
Disability rating						
15 %	\$185	\$200	\$220	\$230	\$230	\$230
15-24.75%	\$185	\$200	\$220	\$230	\$230	\$230
25-69.75%	\$185	\$200	\$220	\$230	\$230	\$230
70-99.75%	\$230	\$250	\$270	\$270	\$270	\$270

Q. How and when are permanent disability benefits paid?

A. Permanent disability benefits are normally paid when temporary disability (TD) benefits end and your doctor indicates you have some permanent effects from your injury. The claims administrator must begin paying your permanent disability payments within 14 days after TD ends. The claims administrator picks which day to pay you and will continue to make payments every two weeks until a reasonable estimate of your disability amount has been paid.

If you have not missed any work, PD payments are due from the date the doctor says you are [permanent and stationary](#) or have reached [maximal medical improvement](#).

Your case may be settled by agreement between you and the claims administrator or a workers' compensation administrative law judge could make a decision in your case following a hearing. There are two basic kinds of settlements:

- **Compromise and release (C&R):** You receive a lump sum payment and become responsible for paying for your future medical care. A settlement like this must be approved by a workers' compensation administrative law judge.
- **Stipulation with request for award (stip):** You and the claims administrator agree on the terms of an award, which usually includes some money and an agreement to pay for future medical treatment. Payments take place over time. A workers' compensation administrative law judge reviews the stip.

If your case goes to a hearing you will receive a findings & award (F&A). This is a written decision by a workers' compensation administrative law judge about your case, including payments and future care that must be provided to you. The F&A becomes a final order unless it's appealed.

If you agree to a stip or receive an F&A, the amount of your permanent disability benefit will be spread over a fixed number of weeks. If you C&R your case you get a lump sum payment. If you have permanent total disability, you are eligible to receive payments for the rest of your life.



In all of these situations your PD payments will likely begin before the final decision about the amount of your PD is reached. That's because, once your doctor says you have permanent disability, the claims administrator will estimate how much you should receive and begin making payments to you before the final percentage of disability has been calculated.

When the actual amount of PD due has been determined, the amount due over the original estimate will be paid.

Q. Why am I receiving so many notice letters?

A. By law, the claims administrator must keep you up to date by sending letters that explain how permanent disability (PD) payment amounts were determined, when you will receive PD payments, why PD payments will be delayed and why PD benefits won't be paid.

Q. Is the claims administrator required to pay a penalty for delays in PD payments?

A. Yes. If the claims administrator sends a payment late, he or she must pay you an additional 10 percent on a self-assessed basis. This is true even if there was a reasonable excuse for the delay and even if the claims administrator sends a letter explaining the delay. You could be awarded a substantial extra payment if there was no reasonable excuse for the delay.

Q. How is my claim finally resolved?

A. After the amount of PD in a claim is determined, there is usually a settlement or award for benefits. This award must be approved by a workers' compensation administrative law judge. If you have an attorney, your attorney should help you obtain this award. If you don't have an attorney, the claims administrator should help you obtain the award. You can also get help from the I&A officer at the local [Division of Workers' Compensation \(DWC\) office](#). If your doctor said further medical treatment for your injury or illness might be necessary, the award may provide future medical care.

There are two types of settlements. A settlement is mutually agreed on by you and the claims administrator.

You can resolve your whole claim through one lump sum settlement called a [compromise and release \(C&R\)](#). A C&R may be best when you want to control your own medical care and/or you want a lump sum payment for your permanent disability. A C&R usually means that after you get the lump sum payment approved by the workers' compensation judge, the claims administrator will not be liable for any further payments or medical care.

You can also agree to a settlement called a stipulation with request for award (stip). A stip usually includes a sum of money and future medical treatment. Payments take place over time. A judge will review the agreement.

If you cannot agree to a settlement with the claims administrator, you can go before a workers' compensation administrative law judge, who will decide your permanent disability award. A judge's finding is called a findings and award (F&A). The F&A generally consists of a sum of money and a provision for the claims administrator to pay for approved future medical treatment.

ABOUT RETURNING TO WORK

Q. I really just want to get back to work. How can I make that happen?

A. Injured workers who return to the job as soon as medically possible have the best outcomes. They recover from their injuries faster and suffer less wage loss. Your decision about returning to work will

be influenced by your doctor, your employer and the claims administrator. Communicate honestly and frequently with them for the best results.

If your doctor decides you cannot return to work while recovering from your injuries you cannot be required to go back to your job.

Sometimes you can go back to your job with work restrictions if your employer is willing to make accommodations. For example, your employer may change certain parts of your job or provide you with new equipment.

If your doctor says you can go back to work with restrictions but your employer is unwilling to accommodate your injuries, you are not required to return to work.

Meanwhile, depending on your injuries, you may be eligible for temporary disability, vocational rehabilitation, supplemental job displacement benefits or permanent disability benefits.

Q. How is my ability to return to work determined?

A. Returning to work safely and promptly can help in your recovery. It can also help you avoid financial losses from being off work. After you are hurt on the job, several people will work with you to decide when you will return to work and what work you will do. These people include:

- Your treating doctor
- Managers who represent your employer
- The claims administrator handling your claim for your employer.

Sometimes doctors and claims administrators do not fully understand your job or other jobs that could be assigned to you. That's why it is important that everyone stay in close contact throughout the process. You (and your attorney if you have one) should actively communicate with your treating doctor, your employer and the claims administrator about:

- The work you did before you were injured
- Your medical condition and the kinds of work you can do now
- The kinds of work your employer could make available to you.

Q. Can I work while I am recovering?

A. Soon after your injury, the treating doctor examines you and sends a report to the claims administrator about your medical condition. If the treating doctor says you are able to work, he or she should describe:

- Clear and specific limits, if any, on your job tasks while recovering. These are called work restrictions. They are intended to protect you from further injury (example: no work that requires repetitive bending or stooping)
- Changes needed, if any, in your schedule, assignments, equipment or other working conditions while recovering (example: provide headset to avoid awkward positions of the head and neck)

- If the treating doctor reports that you cannot work at all while recovering you cannot be required to work.

Q. I have work restrictions. Can I work?

A. If your treating doctor reports that you can return to work under specific work restrictions, any work your employer assigns must meet these restrictions. Your employer might, for example, change certain tasks or provide helpful equipment. Or your employer may say that work like this is not available. If so, you cannot be required to work.

Q. What if I have no work restrictions?

A. If your treating doctor reports that you can return to your job without restrictions, your employer usually must give you the same job and pay you had before you were injured. The employer can require you to take the job. This could happen soon after the injury, or it could happen much later, after your condition has improved.

Q. What if I don't fully recover?

A. Your treating doctor may determine that you will never be able to return to the same job and working conditions you had before you were injured. The doctor should report this in writing. The report should include permanent work restrictions to protect you from further injury.

If you were injured before Jan. 1, 2004, you and the claims administrator first fill out a "description of employee's job duties" on [form RU-91](#). This form is required if you have been off work 90 days. The doctor then reviews what you wrote on the form to determine whether you will be able to go back to your old job and working conditions.

If you were injured on or after Jan. 1, 2004, the doctor will report to your claims administrator about your ability to return to work. You will receive an offer to return to [regular](#), [alternative](#) or [modified work](#) - or not - from your employer, depending on what the doctor's report says. You have a right to review the doctor's report.

Q. How will I know what the other people involved in my claim think about my ability to return to work?

A. If you were injured before Jan. 1, 2004 and your treating doctor reports that you probably will never be able to return to the same job and working conditions you had before you were injured, the claims administrator must keep you advised and send you:

- A letter stating you may be eligible for vocational rehabilitation benefits
- A letter stating whether your employer is offering you a job. Often this is the same letter as above. If you are being offered a job, the claims administrator must also send you an "offer of modified or alternative work" on form [RU-94](#)
- A state pamphlet with information about returning to work
- A copy of the doctor's report described above, with instructions on what to do if you disagree with the report.



If you were injured on or after Jan. 1, 2004, the doctor will report to your claims administrator about your ability to return to work. You will receive an offer to return to [regular](#), [alternative](#) or [modified work](#) – or not - from your employer, depending on what the doctor's report says. You have a right to review the doctor's report.

If you are not offered work and you have permanent disability, you are entitled to [supplemental job displacement benefits](#).

Q. What if my employer offers me work?

A. If the claims administrator's letter says your employer is offering you work, the job must meet the work restrictions in the doctor's report. The offer could involve:

- Regular work: Your old job, paying the same wages and benefits as paid at the time of an injury and located within a reasonable commuting distance of where you lived at the time of your injury
- Modified work: Your old job, with some changes that allow you do to it. If your doctor says you will not be able to return to the job you had at the time of injury, your employer is encouraged to offer you modified work instead of supplemental job displacement benefits or vocational rehabilitation benefits
- Alternative work: A new job with your former employer. If your doctor says you will not be able to return to the job you had at the time of injury, your employer is encouraged to offer you alternative work instead of supplemental job displacement benefits or vocational rehabilitation benefits. The alternative work must meet your work restrictions, last at least 12 months, pay at least 85 percent of the wages and benefits you were paid at the time you were injured, and be within a reasonable commuting distance of where you lived at the time of injury.

If your employer offers you modified or alternative work:

- You may have only 30 days to accept the offer. If you don't respond within 30 days, your employer could withdraw the offer
- The claims administrator probably won't be required to give you vocational rehabilitation benefits. This is true whether or not you accept the offer.

**If you were injured on or after Jan. 1, 2004 and your employer has 50 or more workers, and you are offered regular, modified or alternative work, your weekly permanent disability benefits will be reduced by 15 percent once that offer is made.

**If you were injured on or after Jan. 1, 2004 and your employer has fewer than 50 workers, and you are offered regular, modified or alternative work, your permanent disability benefits will not change. Your employer, however, can be reimbursed up to \$2,500 for modifications they make to the workplace to bring you back.

Q. What if my employer does not offer me work?

A. If the claims administrator's letter says your employer is not offering you work and you were injured before Jan. 1, 2004, the letter must say whether the claims administrator is offering vocational

rehabilitation benefits instead. If you are offered these benefits, you may have only 90 days to reply in writing that you want them. If you don't reply within 90 days, you could lose your right to receive vocational rehabilitation. You have more time to reply if the claims administrator doesn't remind you in writing 45 to 70 days after the original letter. You can preserve your right to receive vocational rehabilitation if:

- You reply that you aren't sure you want vocational rehabilitation and would like an evaluation to help you decide or
- You reply that you want vocational rehabilitation but not right now, and you explain why you aren't ready.

**If you were injured on or after Jan. 1, 2004 and your employer has 50 or more workers, and you are not offered regular, modified or alternative work, your weekly permanent disability benefits will be increased by 15 percent once that offer is made.

**If you were injured on or after Jan. 1, 2004 and your employer has fewer than 50 workers, and you are not offered regular, modified or alternative work, your permanent disability benefits will not change.

Q. Why are my permanent disability benefits affected by the return to work offer?

A. The state's experience and extensive studies have shown that the longer you stay off work the less likely you are to go back, and that leads to more wage loss and a lower quality of life. Permanent disability benefits will never make up for the money you lose by not returning to work, so these provisions were put in place to get you back to your job as soon as medically possible.

Of course, for some people this just may not be possible. Consult an [information & assistance officer](#) or an advocate of your choice if your situation is complex or you need to figure out what other resources are available to you.

Q. What if the job my employer offered does not work out?

A. Depending on your date of injury, you may still be entitled to vocational rehabilitation services or supplemental job displacement benefits if the job does not last for 12 months or your disability prevents you from performing the tasks involved in the job. If you have concerns, talk to your employer or the claims administrator. If that doesn't help, call a state [information & assistance officer](#).

Q: What are vocational rehabilitation benefits and do I qualify for them?

A. Vocational rehabilitation benefits are being phased out in California because of a law passed in 2003. However, if you were injured on the job before Jan. 1, 2004, and are permanently unable to do your usual job, and your employer does not offer other work, you may still qualify for vocational rehabilitation benefits. Vocational rehabilitation benefits include:

- Services to help you find a job
- Payments for living expenses while receiving these services.

Q. Is there a replacement for the vocational rehabilitation program?

A. Yes, but the services are less extensive. If you were injured on or after Jan. 1, 2004, and are permanently unable to do your usual job, and your employer does not offer other work, you may qualify for [supplemental job displacement benefits](#). This benefit is in the form of a voucher that helps pay for educational retraining or skill enhancement -- or both -- at state-approved or state-accredited schools.



Specifically, the law ([Labor Code section 4658.5](#)) says that employees who do not return to work for their employer within 60 days of the end of temporary disability payments will receive a voucher. The amount of the voucher is based on your percentage of disability: