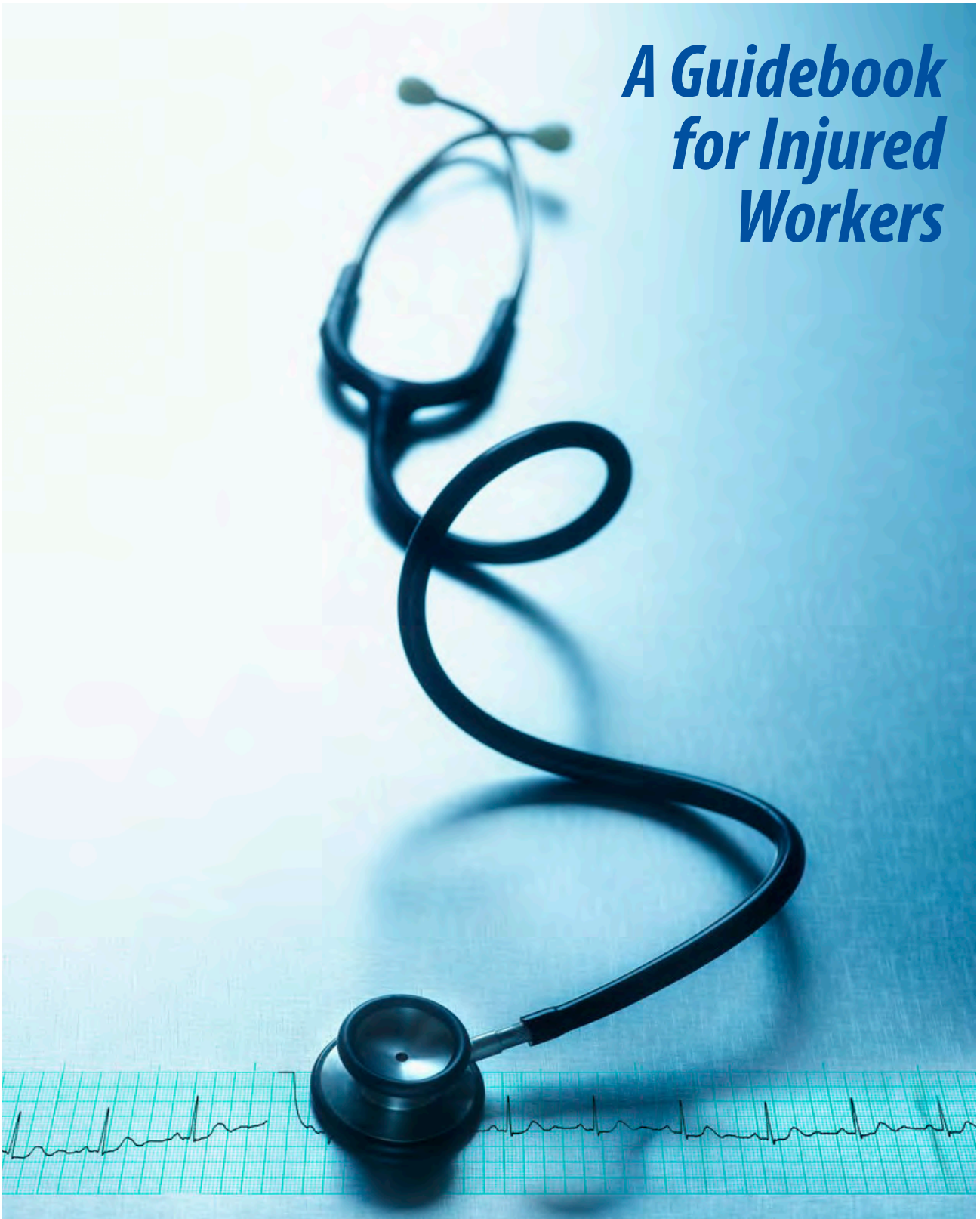


Workers' Compensation in California

A Guidebook for Injured Workers



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This guidebook was designed and produced by the Office of the Director, Department of Industrial Relations (DIR), in consultation with the Division of Workers' Compensation (DWC), State of California. It is based on the third edition of this guidebook, prepared in 2006 by the Institute for Research on Labor and Employment (IRLE) and the Labor Occupational Health Program, University of California, Berkeley, for the Commission on Health and Safety and Workers' Compensation, DIR.

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The guidebook can be viewed and downloaded at www.dir.ca.gov, www.dwc.ca.gov, and www.dir.ca.gov/chswc/. Many public libraries provide access to the Web.

To see a copy of this guidebook, contact an Information & Assistance (I&A) officer of the Division of Workers' Compensation. For the address of an I&A officer in your area, call toll-free 1-800-736-7401, or check the Government Pages at the front of the white pages of a phone book and look up: State Government Offices/Industrial Relations/Workers' Compensation/Information and Assistance.

NOTE: This guidebook lists a variety of sources of information about workers' compensation. Inclusion on this list does not necessarily mean that these persons, organizations, and materials are endorsed, approved, or recommended by the State of California.

CAUTION

The information in this guidebook is true in most situations. However, some rules, exceptions, and deadlines not covered here may apply to you and affect your case. For example, a union contract or a labor-management carve-out agreement may give additional rights or different procedures.

The information here describes the California workers' compensation system as of April 2016. It applies to most private, state, and local government employees whose "date of injury" is 2004 or later.



Christine Baker, Director



*David Lanier, Secretary,
Labor & Workforce Development Agency
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Introduction. How to Use This Guidebook

This guidebook gives an overview of the California workers' compensation system. It is meant to help workers with job injuries understand their basic legal rights, the steps to take to request workers' compensation benefits, and where to seek further information and help if necessary.

The information provided in the guidebook is true in most situations. However, the workers' compensation system is complicated. The guidebook does not fully describe many rules, exceptions, and deadlines that may apply to your case.

For example, if your date of injury was before 2004 or before the dates of injury listed in the different chapters and sections of this guidebook, your benefits and the steps you should take may be different.

Also, a union contract or a labor-management carve-out agreement may give you additional rights or require different procedures. (For information about carve-outs, see *How to Create a Workers' Compensation Carve-Out in California: Practical Advice for Unions and Employers*, listed in Chapter 10.)

All workers, whether or not you have a job injury, should read Chapter 1, The Basics of Workers' Compensation.

If you are an injured worker, you should read Chapter 2, After You Get Hurt on the Job. In that chapter, make sure to review "Keep Your Claim on Track" (p. 9) for basic tips on how to take charge of your case and protect your rights, especially if you are encountering delays or other problems in the workers' compensation system.

The following chapters cover different kinds of workers' compensation benefits, steps you can take to resolve problems with medical care and medical reports, and how to continue working for your employer. You can read some or all of these chapters, depending on your particular situation:

Chapter 3, Medical Care

Chapter 4, Resolving Problems with Medical Care and Medical Reports

Chapter 5, Temporary Disability Benefits

Chapter 6, Working for Your Employer After Injury

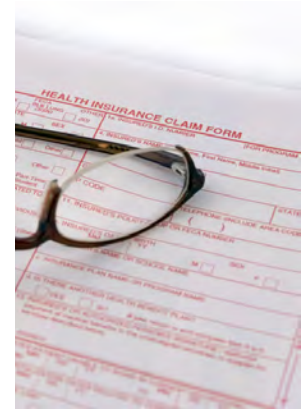
Chapter 7, Permanent Disability Benefits

Chapter 8, Supplemental Job Displacement Benefits

Chapter 9, Return-to-Work Supplement Program

Because this guidebook cannot cover all possible situations faced by injured workers, additional resources are listed in Chapter 10, For More Information and Help. They include government agencies, attorneys, health care providers, unions, and support groups, as well as books and other materials. You should use those resources to learn more about workers' compensation or to get personalized help with your case.

You can use the two appendices for reference. Appendix A lists Important Laws and Regulations that govern your rights and obligations. It also explains how to access the laws and regulations. Appendix B contains a Glossary that briefly explains many of the terms that are commonly used in workers' compensation.



This edition of the guidebook describes the workers' compensation system as of April 2016. Workers using the guidebook should also check updates posted at the Division of Workers' Compensation (DWC) website: www.dwc.ca.gov.

Chapter 1. The Basics of Workers' Compensation



What is workers' compensation?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

- **One event at work.** Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.
or:
- **Repeated exposures at work.** Examples: hurting your hand, back, or other part of the body from doing the same motion over and over, losing your hearing because of constant loud noise.

Workers' compensation covers some, but not all, stress-related (psychological) injuries caused by your job. Also, workers' compensation may not cover an injury that is reported to the employer after the worker is told he or she will be terminated or laid off. For information about what is covered, use the resources in Chapter 10.

What are the benefits?

They can include:

Medical Care. Paid for by your employer, to help you recover from an injury or illness caused by work. This includes doctor visits and other treatment services, tests, medicines, equipment, and travel costs reasonably necessary to treat your injury.

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 and your injury causes a permanent loss of physical or mental function that a doctor can measure.

Supplemental Job Displacement Benefit. A voucher to help pay for retraining or skill enhancement if you are eligible to receive permanent disability benefits, your employer doesn't offer you work, and you don't return to work for your employer. This benefit is available for workers injured in 2004 or later. If your injury also occurred in 2013 or later and you received a Supplemental Job Displacement Benefit, you may also be eligible for an additional, one-time payment under the Return-to-Work Supplement Program.

Death Benefits. Payments to your spouse, children, or other dependents if you die from a job injury or illness.

For examples of workers' compensation payments, see p. 5.

Can my regular doctor treat me if I get hurt on the job?

It depends on whether you tell your employer in **writing—before** you are injured—the name and address of your personal physician or a medical group. This is called “predesignating.” If you predesignate, you may see your personal physician or the medical group right after you are injured.

How to predesignate

To predesignate your personal physician (if you are eligible to do so), you must notify your employer in writing. You may prepare your own written statement, use optional DWC Form 9783 provided by the Division of Workers' Compensation, or use a form provided by your employer. To download DWC Form 9783, go to www.dir.ca.gov/dwc/forms.html.

Note: If your employer or the insurer has a contract with a health care organization (HCO), you must use a different form, discussed on the next page.

Make sure to include the following information:

1. Name of your employer
2. A statement that if you are hurt on the job, you designate your personal physician to provide medical care. Give the name, address, and phone number of your physician.
3. Your name
4. Your signature
5. Date

You can predesignate a doctor of medicine (MD) or doctor of osteopathy (DO) who treated you in the past and has your medical records. The doctor must be a general practitioner, internist, pediatrician, obstetrician-gynecologist, or family practitioner who is your primary care physician.

You cannot predesignate your personal chiropractor or acupuncturist, but if you give your employer the name of your personal chiropractor or acupuncturist in writing before you are injured, you may switch to this chiropractor or acupuncturist upon request, after you first see a doctor chosen by a claims administrator (a person who handles workers' compensation claims for your employer).

You may also predesignate a medical group if it meets the following criteria:

- Is composed of licensed doctors of medicine (MD) or doctors of osteopathy (DO)
- Offers and coordinates both primary care and care in other medical specialties
- Mostly treats medical conditions that are unrelated to work

You cannot predesignate unless the physician or medical group you predesignate agrees in advance to treat you for job injuries and illnesses. You can document the agreement by having the physician, an employee of the physician, or an employee of the medical group sign the predesignation form, or by some other form of documentation. Include the documentation when you give your employer the predesignation form or statement.

If you predesignate, you may see your personal physician or medical group right after you are injured.

Can all workers predesignate?

No. You can predesignate only if, on your date of injury, you have health care coverage for medical conditions that are unrelated to work. If you do not have this coverage, you do not have a right to predesignate.

Are there different rules for predesignating if my employer or the insurer has a contract with a health care organization (HCO)?

Yes. A health care organization (HCO) is an organization certified by the Division of Workers' Compensation to provide managed medical care to injured workers. If your employer or the insurer has a contract with an HCO, the employer or insurer must give you DWC Form 1194 within 30 days after your date of hire and at least once a year. You can use this form to predesignate your personal physician, personal chiropractor, or personal acupuncturist. You are not required to show that your doctor agreed to be predesignated. If you do not predesignate each time you are given this form, your employer will enroll you in the HCO and you will be treated in the HCO for job-related injuries.

What should I do if I get hurt at work or develop a work-related medical problem?

Report the injury or illness to your employer. Make sure your supervisor or someone else in management knows as soon as possible. If your injury or illness developed gradually (like tendinitis or hearing loss), report it as soon as you learn or believe it was caused by your job. Reporting promptly helps avoid problems and delays in receiving benefits, including medical care. If your employer does not learn about your injury within 30 days, you could lose your right to receive workers' compensation benefits.

Get emergency treatment if needed. If it's an emergency, call 911 or go to an emergency room right away. Your employer must make sure that you have access to emergency treatment right away and may tell you where to go for treatment. Tell the medical staff that your injury or illness is job-related.

For more steps to take, see Chapter 2.

How can I avoid getting hurt on the job?

It's best to prevent injuries before they happen. 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. Report unsafe conditions to your employer and union, if you have one. If they don't respond, call Cal/OSHA, the state agency that enforces health and safety laws.

Did you know?

- Medical care must be paid for by your employer if you get hurt on the job—whether or not you miss time from work.
- You may be eligible to receive benefits even if you are a temporary or part-time worker.
- You may be covered by workers' compensation as an employee even if you are called an "independent contractor."
- You don't have to be a legal resident of the United States to receive most workers' compensation benefits.
- You receive benefits no matter who was at fault for your job injury.
- You can't sue your employer for a job injury (in most cases).
- It's illegal for your employer to punish or fire you for having a job injury or for requesting workers' compensation benefits when you believe your injury was caused by your job.

Workers' Compensation Benefits—Examples

Temporary Total Disability Benefits

DATE OF INJURY	MINIMUM PAYMENTS	MAXIMUM PAYMENTS
2010	\$148.00 per week	\$986.69 per week
2011	\$148.00 per week	\$986.69 per week
2012	\$151.57 per week	\$1,010.50 per week
2013	\$160.00 per week	\$1,066.72 per week
2014	\$161.19 per week	\$1,074.64 per week
2015	\$165.49 per week	\$1,103.29 per week
2016	\$169.26 per week	\$1,128.43 per week

Permanent Disability Benefits—Examples

The following are only examples. They apply to workers who earned more than \$435 per week before injury, and whose employer has fewer than 50 employees. The examples are not adjusted for age, occupation, or other factors causing disability (apportionment).

DISABILITY	INJURY IN 2005-12	INJURY IN 2013	INJURY IN 2014
Total loss of vision in one eye, normal vision in other eye	\$19,665.00 (total)	\$27,312.50 (total)	\$34,437.50 (total)
Amputation of index finger at middle joint	\$6,210.00 (total)	\$7,877.50 (total)	\$9,932.50 (total)

Supplemental Job Displacement Benefits

DATE OF INJURY	MAXIMUM BENEFIT
2004–12	\$4,000 to \$10,000, depending on permanent disability rating
2013 or later	\$6,000

Death—Examples involving three or more total dependents

The following are only examples. Benefits are also available if there are fewer than three total dependents, or if there are partial dependents.

Burial expenses:

Date of injury before 2013: up to \$5,000

Date of injury 2013 or later: \$10,000

Death benefits if there are three or more total dependents:

Date of injury 2006 or later: \$320,000 (total)

(Regardless of the amounts listed above, death benefits paid to a totally dependent child continue until the child reaches age 18. If the child is physically or mentally incapacitated, benefits continue until the child's death.)

Chapter 2. After You Get Hurt on the Job



What should I do after reporting my injury or illness to my employer?

After reporting your injury and getting emergency treatment if needed (see Chapter 1), follow the steps below.

Fill out a claim form and give it to your employer

Your employer must give or mail you a Workers' Compensation Claim Form (DWC 1) within one working day after you report your injury or illness (or your employer learns about it). You use this form to request workers' compensation benefits. If your employer does not give you a claim form, get one from an Information & Assistance officer (see pp. 48–49).

Read all of the information that comes with the claim form. Fill out and sign the “employee” portion of the form. Describe your injury completely. Include every part of your body affected by the injury. Give the form to your employer. This is called “filing” the claim form. Do this right away to avoid possible problems with your claim. If you mail the form to your employer, use first-class or certified mail and buy a return receipt.

Get good medical care

You should be treated by a doctor who understands your particular type of injury or illness. Chapter 3 explains how this doctor, called your “primary treating physician,” is chosen. The role of this doctor is to:

- Prescribe care for your job injury or illness and manage your overall care
- Help determine when you can return to work
- Help identify the kinds of work you can do safely while recovering
- Refer you to specialists if necessary
- Write medical reports that will help determine the benefits you receive.

Tell the doctor about your symptoms and the events at work that you believe caused them. Also describe your job and your work environment.

What happens after I file the claim form?

Your employer must fill out and sign the “employer” portion of the form and give the completed form to a claims administrator. This person handles workers' compensation claims for your employer. (Most claims administrators work for insurance companies or other organizations that handle claims for employers. Some claims administrators work directly for large employers that handle their own claims. This person may also be called a claims examiner or claims adjuster.) Your employer must give or mail you a copy of the completed form within one working day after you filed it. **Keep this copy.**

The claims administrator must decide within a reasonable time whether to accept or deny your claim.

For tips on how to keep your claim on track, see p. 9. See also Chapter 10.

“Accepting” the claim means the claims administrator agrees your injury is covered by workers’ compensation. If your claim is accepted, you will receive paid medical care for your injury. You may also be eligible for payments to help make up for lost wages. To learn about these payments, see Chapter 5.

“Denying” the claim means the claims administrator believes your injury is not covered by workers’ compensation. If the claims administrator sends you a letter denying your claim, you have a right to challenge the decision. Don’t delay, because there are **deadlines** for filing the necessary papers. To get help with your claim, use the resources in Chapter 10.

If I haven’t heard from the claims administrator, is my claim accepted?

The claims administrator must decide within a reasonable time whether to accept or deny your claim. If you have questions about a delay with your claim, use the resources in Chapter 10. If the claims administrator doesn’t send you a letter denying your claim within 90 days after you filed the form or reported your injury, your claim is considered accepted in most cases.

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

Your primary treating physician is responsible for explaining in a medical report:

- What kind of work you can and can’t do while recovering
- What changes are needed in your work schedule or assignments.

You, your primary treating physician, 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. See Chapter 6.

If you disagree with your primary treating physician, you must promptly write to the claims administrator about the disagreement, or you may lose important rights. To review the steps you can take if you disagree with a medical report, see Chapter 4.

NOTE

On the claim form, you will see a message telling you that it is against the law for anyone to commit fraud in order to:

- Obtain workers’ compensation benefits or payments, or
- Deny an injured worker these benefits.

Fraud is a felony. This law applies to everyone in the workers’ compensation system, including injured workers, employers, claims administrators, doctors, and attorneys.

To report fraud, contact a local district attorney’s office or the California Department of Insurance (DOI).

You can call the DOI toll-free at 1-800-927-4357, and ask for the phone number of the nearest office of their Fraud Division.

See also the DOI website: www.insurance.ca.gov/0300-fraud/.

I'm afraid I might be fired because of my injury. Can my employer fire me?

It's illegal for your employer to punish or fire you for having a job injury, or for filing a workers' compensation claim when you believe your injury was caused by your job. It's also illegal for your employer to punish or fire co-workers who testify in your case. The California Labor Code (section 132a) prohibits this kind of discrimination.

Also, the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) say that an employer with 50 or more employees usually must let you take unpaid leave for up to 12 weeks, without losing your job, if you need time off for a serious medical condition.

If you do not fully recover from your injury, the federal Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA) make it illegal for your employer to discriminate against you because of a serious disability.

If you feel your job is threatened, find someone who can help. Use the resources in Chapter 10. Note that there are deadlines for taking action to protect your rights.

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

Other types of assistance may be available:

- State Disability Insurance (SDI) or, in some cases, unemployment insurance (UI) benefits paid by the Employment Development Department (EDD) when workers' compensation payments are delayed or denied. (You should file a claim for SDI or UI benefits if you are not working because of your injury, in case there is a problem with your workers' compensation claim. Make sure to tell the EDD about your workers' compensation claim.)
- Social Security disability benefits paid by the US Social Security Administration (SSA) for total disability (these benefits may be reduced by workers' compensation payments that you receive).
- Benefits offered by employers and unions, such as sick leave, group health insurance, long-term disability insurance (LTD), and salary continuation plans.
- A claim or lawsuit if your injury was caused by someone other than your employer.

To learn more about these other kinds of assistance, use the resources in Chapter 10.



Keep your claim on track

Whether or not you have a problem:

- **Keep good records.** You will probably fill out and receive many forms and other papers. Keep copies of *everything*, including envelopes showing postmarks!
 - Keep notes of all discussions you have with the people involved in your claim.
 - Keep track of your medical condition and how it affects your ability to work.
 - Request in writing that the claims administrator give you copies of all medical reports and other documents.
 - Save pay stubs and time sheets before and after your injury showing your income, the dates you worked, and when you were off work.
 - Keep records of any out-of-pocket expenses that workers' compensation could cover (like prescriptions or travel costs to medical appointments).
- **Learn more about workers' compensation.** The laws and procedures in workers' compensation are complicated. What applies to another injured worker may not apply to you. Learn what your rights are, and don't be afraid to ask questions. Use the resources in Chapter 10.

Many injured workers get their benefits quickly, with no trouble at all. Others face problems and delays. This page gives tips on how to take charge of your case and make sure your rights are protected.

If you have a concern, speak up. See whether **your employer** or the **claims administrator** can agree to resolve the problem. If this doesn't work, don't delay getting help. Try the following:

- **Contact an Information & Assistance officer.** I&A officers answer questions and help injured workers. They may provide information and forms and help resolve problems. Some I&A officers hold workshops for injured workers. For more information, see pp. 48–49, or go to www.dwc.ca.gov. To contact a local office, check the Government Pages at the front of the white pages of your phone book. Look under: *State Government Offices/Industrial Relations/Workers' Compensation*.
- **Consult an attorney.** Lawyers who represent injured workers in their workers' compensation cases are called applicants' attorneys. Their job is to protect your rights, plan a strategy for your case, gather information to support your claim, keep track of deadlines, and represent you in hearings before a workers' compensation judge. For more information, see p. 56. You can get names of applicants' attorneys from the State Bar of California (1-415-538-2120; website: www.calbar.ca.gov), a local bar association, or the California Applicants' Attorneys Association (1-800-648-3132 within California; website: www.caaa.org).
- **Contact your union.** Your union may be able to help resolve problems, tell you about other benefits, negotiate changes needed in your job, protect you from job discrimination, and refer you to legal services.
- **Represent yourself.** If you can't get help from the above resources, you can prepare your own case and request a hearing before a workers' compensation judge. For instructions, contact an Information & Assistance officer (see above).

Chapter 3. Medical Care



For tips on how to keep your claim on track, see p. 9. See also Chapter 10.

Who pays for my medical care?

Your employer pays for medical care for your work-related injury or illness, either through a workers' compensation insurance policy or by being self-insured. The claims administrator pays the medical bills. You should never receive a medical bill, as long as you filed a claim form and your physician knows that the injury is work-related.

It is illegal for a physician or medical facility to bill a worker if they know the injury is or may be work-related. This law is found in California Labor Code section 3751(b).

What kind of medical care is available to injured workers?

California workers' compensation law requires claims administrators to authorize and pay for medical care that is "reasonably required to cure or relieve" the effects of the injury. This means care that follows scientifically based medical treatment guidelines.

Medical treatment guidelines used in California

The medical treatment guidelines currently being used in California are in the medical treatment utilization schedule (MTUS) published by the Division of Workers' Compensation (DWC). The current MTUS includes portions of the Occupational Medicine Practice Guidelines, Second Edition, published by the American College of Occupational and Environmental Medicine (ACOEM), as well as other guidelines. They also include guidelines for acupuncture treatment, chronic pain treatment, and post-surgical treatment. The MTUS is currently being updated.

The medical treatment guidelines are designed to help physicians give appropriate treatment. This includes advising and guiding the injured worker on how to remain active while recovering, and informing the employer about the kinds of changes at work that are needed to promote recovery. Such changes could involve different job assignments, reduced working hours, or other accommodations that are safe and appropriate for the particular injury.

If your doctor recommends treatment that is not in the guidelines

Some injured workers have medical conditions requiring treatment that is not in the MTUS. If your doctor recommends treatment not in those guidelines, the claims administrator is required to pay for the treatment if it follows other scientifically based guidelines that are generally recognized by the national medical community. (Some treatment guidelines, for example, are available online at the website of the National Guideline Clearinghouse: www.guideline.gov.)

If your case is settled with an agreement on future medical care

If you and the claims administrator settled your workers' compensation case with an agreement that you will continue to receive medical care for your injury, the medical treatment guidelines and rules described above still apply to you. The guidelines and rules apply to **all** treatment, even in cases that settled before medical treatment guidelines were added to workers' compensation law.

Limits on chiropractic, physical therapy, and occupational therapy visits

If your date of injury is in 2004 or later, you are limited to 24 chiropractic visits, 24 physical therapy visits, and 24 occupational therapy visits for your injury (except for visits under the post-surgical treatment guidelines above), unless the claims administrator authorizes additional visits in writing. Also, regardless of your date of injury, you may be subject to other limits on these visits based on the medical treatment guidelines described above.

When does my medical care start?

If it's an emergency, your employer must make sure that you have access to emergency treatment right away. For non-emergency care, the claims administrator is required to authorize treatment within one working day after you file a claim form. While investigating your claim, he or she must authorize necessary treatment up to \$10,000.

What should I do 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. This law is found in California Labor Code section 5401(c). Ask for treatment to be authorized now, while waiting for a decision on your claim.

If the claims administrator won't authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator.

If you don't have health insurance, try to find a doctor, clinic, or hospital that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

To challenge the claims administrator's decision not to authorize treatment, to request penalties, or to file a complaint, see Chapter 4.

Did you know?

- Your employer is required to post information about your workers' compensation rights, including the right to predesignate your personal physician in case of job injury.
- If your employer or the insurer created a medical provider network (MPN), the employer or insurer is required to give you written information about rights, procedures, and services while being treated within the network.
- You have a right to request and receive copies of all medical reports that affect your benefits.
- You have a right to have another person present during a medical examination or to tape record the examination. **Note:** You should tell the doctor if you plan to tape record the examination.

For non-emergency care, who can treat me right after I am injured?

It depends on whether your employer or the insurer has created a medical provider network (MPN) or has a contract with a health care organization (HCO) to treat injured workers, and whether you previously predesignated your personal physician or a medical group.

If you previously predesignated your personal physician or a medical group

Workers with health care coverage for conditions unrelated to work are allowed to predesignate their personal physician or a medical group before injury. For information on how to predesignate, see Chapter 1. If you predesignated, you may see your personal physician or the medical group right after you are injured.

If there is a medical provider network (MPN)

An MPN is a group of physicians and other health care providers who treat injured workers. MPNs must be approved by the Division of Workers' Compensation (DWC). An employer or insurer that has an MPN must give you written information about the MPN.

If your employer or the insurer has an MPN, in most cases you will first be treated in the MPN after you are injured, unless you predesignated.

If there is a health care organization (HCO)

An HCO is an organization certified by the DWC that contracts with an employer or insurer to provide managed medical care for injured workers. Most employers and insurers do *not* have contracts with HCOs. An employer or insurer that has a contract with an HCO must give employees a form prepared by the Division of Workers' Compensation, DWC Form 1194, to allow them to choose whether to enroll in the HCO. This form must be given to new employees within 30 days after date of hire and to current employees at least once a year. The form is in the California Code of Regulations, title 8, section 9779.4, and can be downloaded. (For instructions on how to access the regulations, see Appendix A.)

If your employer or the insurer has a contract with an HCO, in most cases you will first be treated in the HCO after you are injured, unless you predesignated.

If there is *no* MPN or HCO

If your employer or the insurer does not have an MPN and does not have a contract with an HCO, in most cases the claims administrator can choose the doctor who first treats you after you are injured, unless you predesignated.

Other situations where you can choose who treats you right after injury

Sometimes an injured worker has a right to choose the primary treating physician even if he or she did not predesignate:

- If your employer did not post required information about your workers' compensation rights and has not offered treatment after learning about your injury, you can go to your personal physician right after you are injured.
- If your employer or the insurer sends you to treatment that is completely inadequate or refuses to provide necessary care, you can go to a physician of your choice. This does not have to be your personal physician.

If you believe one of these situations applies and you would like to be treated by your personal physician or another physician of your choice, get help immediately to avoid a possible dispute about who can choose the physician. Use the resources in Chapter 10.

Can I switch to a different doctor for treatment?

Yes. However, your choices depend on whether you are being treated in a medical provider network (MPN) or a health care organization (HCO) and whether you predesignated your personal physician.

Choices if you are being treated in an MPN

If you are being treated in an MPN, after the first medical examination for your injury, you are allowed to switch to another doctor within the MPN, and you may switch again whenever it is reasonable to do so. Your employer or the insurer must give you written information on how to do this and, starting January 1, 2014, offer services to help you find an available doctor. In most cases, you are not allowed to switch to a doctor outside the MPN.

Choices if you are being treated in an HCO

If you are being treated in an HCO, you are allowed to switch at least one time to another doctor within the HCO. The HCO must give you a choice of physicians within 5 days after you request a change.

If you are covered by employer-provided health insurance, then 180 days after your injury or illness is reported to your employer, you are allowed to switch to a doctor outside the HCO. If you are **not** covered by employer-provided health insurance, then 90 days after your injury or illness is reported to your employer, you are allowed to switch to a doctor outside the HCO.

When you switch to a doctor outside the HCO, the new doctor can be a medical doctor, osteopath, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractor. (A chiropractor may not be your treating physician, however, after you have received your maximum number of chiropractic visits, as described on p. 11.) You or the new doctor must give the claims administrator the doctor's name and address. This allows the claims administrator to obtain medical reports and pay for your medical care. You may switch again whenever it is reasonable to do so.

Choices if you are **not** being treated in an MPN or HCO and you did **not** predesignate

If you are **not** being treated in an MPN or HCO and you did **not** predesignate your personal physician, you have a right to switch to a new doctor one time during the first 30 days after your injury or illness is reported to your employer. However, the claims administrator is usually allowed to choose the new doctor. But if you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to your chiropractor or acupuncturist upon request, after you first see a doctor chosen by the claims administrator. (A chiropractor may not be your treating physician, however, after you have received your maximum number of chiropractic visits, as described on p. 11.)

After 30 days, you are allowed to switch to a doctor of your choice if you still need medical care and your employer or the insurer still has not created an MPN. The new doctor can be a medical doctor, osteopath, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractor. (A chiropractor will be subject to the maximum number of visits described on p. 11.) You or the new doctor must give the claims administrator the doctor's name and address. This allows the claims administrator to obtain medical reports and pay for your medical care. You may switch again whenever it is reasonable to do so.

Choices if you are being treated by a predesignated personal physician

If there is an MPN: If you are being treated by a doctor you predesignated and your employer or the insurer has an MPN, you may switch to a new doctor within the MPN, and you may switch again within the MPN whenever it is reasonable to do so. Your employer or the insurer must give you written information about how to select a doctor within the MPN and, starting January 1, 2014, offer services to help you find an available doctor. However, your predesignated personal physician may refer you to another doctor outside the MPN for consultation or specialized treatment.

If there is an HCO: If you are being treated by a doctor you predesignated and your employer or the insurer has a contract with an HCO, you may switch to a new doctor within the HCO. You may switch again within the HCO and later to a doctor outside the HCO as described above, under “Choices if you are being treated in an HCO.”

If there is *no* MPN or HCO: If you are being treated by a doctor you predesignated and your employer or the insurer does not have an MPN and does not have a contract with an HCO, you may switch doctors as described above, under “Choices if you are not being treated in an MPN or HCO and you did not predesignate.”

How can I avoid problems in getting appropriate treatment?

Understand your primary treating physician’s treatment plan, and request copies of all medical reports about your injury written by your primary treating physician and any specialists. These reports, which the doctors are required to send to the claims administrator, describe the nature of your injury, causes of the injury, necessary treatment, and types of work you can do while recovering. The doctor and claims administrator are required to give you copies if you request them (except in some cases when the request is for mental health records). If you have questions about a particular report, ask the doctor.

Chapter 4. Resolving Problems with Medical Care & Medical Reports

I don't agree with a medical report written by my primary treating physician or other treating doctor. What can I do?

If you have questions about a particular report, ask your primary treating physician or the other doctor. Sometimes different doctors have different opinions about the cause of an injury, the treatment that is needed, the type of work that you can do while recovering, or other questions. You have a right to challenge a medical report.

What can I do if I don't agree with the doctor about necessary treatment?

If you don't agree about necessary treatment, you have a right to get another doctor's opinion. The steps to take to get another opinion depend on whether you are receiving care within a medical provider network (MPN), a health care organization (HCO), or neither.

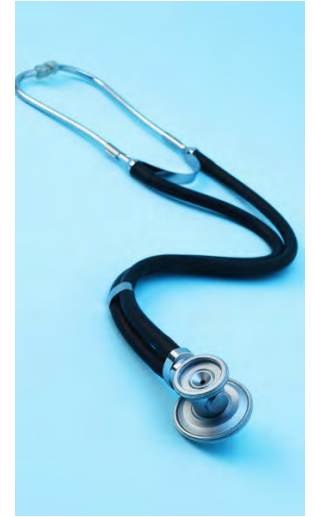
Note: You use the steps described below only to challenge an opinion about the kinds of medical tests or treatment you need. If you want to challenge another type of opinion in a medical report, such as an opinion about the causes of your injury or the kinds of work you can do, see pp. 17 and 20.

Steps to take if you are being treated in an MPN

If you are receiving care within an MPN and wish to challenge the treatment prescribed by a doctor who is treating you, first consider switching to another doctor within the MPN. Your employer or the insurer must give you written information on how to change doctors within the MPN. See if you can reach agreement with the new doctor.

If you cannot reach agreement with the new doctor, you can obtain opinions from up to two more doctors within the MPN. These are called second and third opinions. Your employer or the insurer must give you written information on how to do this. You must make appointments to see these doctors within 60 days after you receive a list of available doctors from the claims administrator. If you don't make the appointments within 60 days, you risk losing the right to get the other doctors' opinions.

If you do not agree with the second and third doctors, you can obtain an independent medical review arranged by the Division of Workers' Compensation (DWC). If that doctor agrees with you about necessary treatment, you may obtain the treatment from a physician outside the MPN.



For tips on how to keep your claim on track, see p. 9. See also Chapter 10.

Steps to take if you are being treated in an HCO

If you are receiving care within an HCO and wish to challenge the treatment prescribed by a doctor who is treating you, first consider switching to another doctor within the HCO. The HCO must give you a choice of physicians within 5 days after you request a change. See if you can reach agreement with the new doctor.

If you cannot reach agreement with the new doctor, you can obtain an opinion from another doctor within the HCO. If you do not agree with this doctor, you can ask the HCO to resolve the dispute. The HCO must use an “expedited grievance procedure” to issue a written decision within 30 days, or sooner if your condition requires a faster decision.

Steps to take if you are *not* being treated in an MPN or HCO

If you are *not* receiving care within an MPN or HCO and wish to challenge the treatment prescribed by a doctor who is treating you, first consider switching to another doctor (see pp. 13-14).

If you cannot switch or cannot reach agreement with the new doctor, you can take the steps below:

1. Send a letter to the claims administrator stating that you disagree with the medical report.

- If you do *not* have an attorney, you must send the letter within 30 days after you receive the report.
- If you have an attorney, your attorney must send the letter within 20 days after receiving the report.

If the letter is not sent before the applicable deadline, you risk losing the right to challenge the treating doctor’s opinion.

2. Get a medical opinion, or evaluation, from another doctor.

For instructions on how to do this, see the next page.

How to Get a Medical Evaluation

If you do *not* have an attorney:

- After receiving your letter stating that you disagree with a medical report, the claims administrator must send you a form and instructions on how to select a qualified medical evaluator (QME). QMEs are doctors who are certified by the Division of Workers' Compensation (DWC) to conduct medical evaluations in workers' compensation cases.
- After the claims administrator sends you the form and instructions, you have 10 days to fill out the form and mail it to the DWC. When you fill out the form, you must select the medical specialty of the QME. After the DWC sends you a panel, you have 10 days to choose a QME from the panel, make an appointment to be examined by the QME, and tell the employer of your choice and appointment time. If you do not meet these deadlines, the claims administrator will have the right to choose from the panel the doctor you must see.

If you have an attorney:

- Your attorney and the claims administrator may agree on a doctor called an agreed medical evaluator (AME). AMEs are not required to be certified by the DWC.
- If you were injured in 2005 or later and agreement on a doctor is not reached, your attorney or the claims administrator may request from the DWC a panel (list) of three QMEs. Your attorney and the claims administrator may agree on someone from this panel. If agreement cannot be reached, your attorney and the claims administrator may each strike one name from the panel, and the remaining QME will conduct the evaluation.
- If you were injured before 2005 and agreement on a doctor cannot be reached, your attorney will select a QME, and the claims administrator may also select a QME to conduct an additional evaluation.

Important! The QME or AME will examine you and write a report describing your condition and addressing the dispute. This is called a "medical-legal report." You or your attorney should select the appropriate medical specialty and choose the QME or AME carefully. The medical-legal report will affect your benefits. In many cases, you will not be able to choose another QME or AME. For help, use the resources in Chapter 10.

For more information about medical evaluations, call the DWC's Medical Unit at 1-800-794-6900, or visit the website: www.dir.ca.gov/dwc/MedicalUnit/imchp.html.

I agree with a treating doctor about necessary treatment. How long can the claims administrator take to decide whether to authorize treatment?

This depends on whether your medical condition is considered urgent. Claims administrators must decide whether to authorize and pay for treatment within time frames that are part of the utilization review (UR) process described below.

Decisions based on utilization review (UR)

In the utilization review process, the claims administrator may approve treatment. However, he or she is not permitted to change or deny treatment. Only a physician who is qualified to evaluate the recommended treatment may do this. This person is called a “physician reviewer.” If a physician reviewer changes or denies treatment, the claims administrator will communicate the decision to you and your treating physician.

- **If your medical situation is considered urgent:** This means you face a serious threat to your health, or the normal time frame for a decision could harm your ability to recover fully. If this is the case, the decision to authorize treatment must be made in a timely fashion not to exceed 72 hours after the claims administrator receives the information needed to make the decision. The claims administrator must communicate the decision within 24 hours.
- **If your medical situation is *not* considered urgent:** The decision to authorize treatment must be made in a timely fashion not to exceed 5 working days after the claims administrator receives the physician’s request for authorization along with the information needed to make the decision. If the claims administrator needs more time to obtain necessary information, the decision can be made up to 14 days after receiving the physician’s request. The claims administrator must communicate the decision within 24 hours.

What you can do to speed up the decision-making process

Sometimes treatment is delayed because the claims administrator has not received all of the information needed from a treating physician. Other times, the claims administrator does not send all of the information to the physician reviewer. To help avoid delay:

- Encourage the treating physician to respond promptly to questions and requests from the claims administrator about your medical condition and why you need the recommended treatment. Also encourage the doctor to identify, if possible, any scientifically based medical treatment guidelines that support the recommended treatment. If treatment does not follow the medical treatment utilization schedule (MTUS) used in California (described on p. 10) or other scientifically based guidelines, the treating physician must show why the treatment is needed.
- Encourage the claims administrator to promptly send all of the information to the physician reviewer.

Can treatment recommended by a treating doctor be denied?

Yes. A physician reviewer may deny treatment if there is no scientific basis for the treatment. The claims administrator must clearly explain the physician reviewer's reasons for denying treatment.

I don't agree with a decision to deny treatment. What can I do?

To challenge a decision to deny treatment recommended by a treating physician, you can request independent medical review (IMR) using the IMR request form that the claims administrator must include with any decision to deny treatment. You must do this within 30 days after you received the decision from the claims administrator. You may designate another person to request IMR on your behalf, and your treating physician may join with or assist you in requesting IMR. For more information, call the DWC's Medical Unit at 1-800-794-6900, or visit the DWC's IMR website: www.dir.ca.gov/dwc/IMR.htm.

Penalties for treatment being delayed or denied

If the claims administrator delays or denies treatment without any reasonable excuse, you could be awarded a penalty payment of up to 25 percent of the value of each service that was unreasonably delayed or denied, up to \$10,000. For help in requesting penalty payments, contact an Information & Assistance (I&A) officer or an attorney (see Chapter 10).

How to file a complaint about treatment being delayed or denied

The Audit Unit of the Division of Workers' Compensation (DWC) investigates complaints and imposes penalties if a claims administrator misses utilization review (UR) deadlines in deciding whether to authorize and pay for treatment. The Audit Unit also imposes large monetary penalties when a claims administrator unreasonably delays or denies medical care and other benefits "with a frequency that indicates a general business practice." Audit penalties are paid to the state, not to the injured worker. For instructions on how to file a complaint with the Audit Unit, contact an I&A officer (see Chapter 10).

What can I do if I don't agree with a treating doctor on matters other than treatment?

If you wish to challenge opinions in a medical report other than those about treatment, first consider switching to another doctor. If you cannot switch or cannot reach agreement with the new doctor, you can take the steps below.

1. Send a letter to the claims administrator stating that you disagree with the medical report.

- If you do *not* have an attorney, in some cases you must send the letter within 30 days after you received the report.
- If you have an attorney, in some cases your attorney must send the letter within 20 days after receiving the report.

If the letter is not sent before the applicable deadline, you risk losing the right to challenge the treating doctor's opinion.

2. Get a medical opinion, or evaluation, from another doctor.

For instructions on how to do this, see p. 17.

If the claims administrator doesn't agree with a treating doctor on matters other than treatment, what can the claims administrator do?

The claims administrator can require you to be examined by a QME or AME. Here is how the QME or AME would be selected:

- **If you do *not* have an attorney:**

The claims administrator can require you to be examined by a QME. The claims administrator must send you instructions on how to contact the DWC and must let *you* select the QME. After the claims administrator sends you these instructions, make sure to take the steps and meet the deadlines described on p. 17.

- **If you have an attorney:**

The steps that are taken are described on p. 17.

Chapter 5. Temporary Disability Benefits

What are temporary disability benefits?

If your injury prevents you from doing your usual job while recovering, you may be eligible for temporary disability (TD) benefits. TD benefits are payments you receive if you lose wages because:

- Your treating doctor says you are unable to do your usual job for more than three days, or you are hospitalized overnight;
and
- Your employer does not offer you other work that pays your usual wages while you recover.

What are the different types of TD benefits?

There are two types of TD benefits:

- If you cannot work *at all* while recovering, you receive temporary *total* disability (TTD) payments.
- If you can do *some* work while recovering and your employer offers you this type of work, you receive temporary *partial* disability (TPD) payments if your wages while recovering are below a maximum limit set by law.

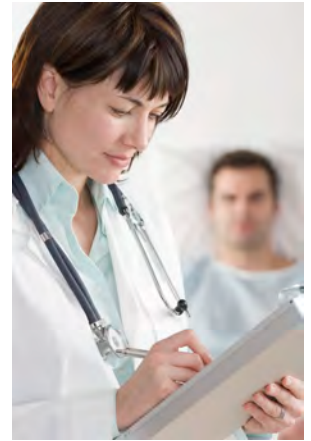
How much are TD benefits?

As a general rule, TD benefits are two-thirds of the gross (pre-tax) wages you lose while you're recovering from a job injury. However, you can't receive more than a maximum weekly amount or less than a minimum weekly amount, as set by law.

You don't pay federal, state, or local income taxes on TD benefits. Also, you don't pay Social Security taxes, union dues, or retirement fund contributions on these benefits.

The information in this chapter gives you a rough idea of TD benefit amounts. Determining exact TD amounts can be complicated, especially for workers who:

- Had a second job when injured
- Had seasonal jobs
- Had wages that rose or fell
- Earned other income, such as tips, overtime, bonuses, housing, clothing, or car allowances
- Were scheduled for a wage increase after the date of injury
- Received TD benefits more than two years after the date of injury.



For tips on how to keep your claim on track, see p. 9. See also Chapter 10.

Other Benefits Besides TD

- If you are hurt on the job, your employer must pay for medical care to help you recover. See Chapter 2.
- You may be eligible for other financial assistance, such as State Disability Insurance, if TD payments are delayed or denied. To find out about these benefits, see Chapter 10.
- TD benefits are paid only while you are recovering. Some injured workers later receive other types of benefits. To find out about these other benefits, see Chapters 6, 7, and 8.
- All public employers and private employers with 50 or more employees must grant job-protected leave to workers who have a serious health problem or who need to care for a child or other family member. This is governed by the California Family Rights Act (CFRA) and the federal Family and Medical Leave Act (FMLA). Job-protected leave may run concurrently with time off work while receiving TD benefits.

What payments do I receive if I'm on TTD?

Temporary total disability (TTD) payments are usually two-thirds of the wages you were earning before you were injured.

Example: If the gross wages that you would be earning if you were not injured are \$300 per week, your TTD payments are \$200 per week.

Maximum Limits on TTD Payments

You can't receive more than a maximum weekly amount set by law. Therefore, if you earned more than a certain amount of wages before you were injured, you could receive less than two-thirds of those wages.

The maximum depends on your date of injury. Here are some examples:

- If your date of injury is in 2014 and your gross wages before injury were more than \$1,611.96 per week, your TTD payments are the maximum: \$1,074.64 per week.
- If your date of injury is in 2015 and your gross wages before injury were more than \$1,654.94 per week, your TTD payments are the maximum: \$1,103.29 per week.
- If your date of injury is in 2016 and your gross wages before injury were more than \$1,692.65 per week, your TTD payments are the maximum: \$1,128.43 per week.

For particular examples, see p. 25.

Minimum TTD Payments for Low-Wage Workers

You can't receive less than a minimum weekly amount set by law. Therefore, if you earned less than a certain amount of wages before you were injured, you could receive more than two-thirds of those wages.

The minimum depends on your date of injury. Here are some examples:

- If your date of injury is in 2014 and your gross wages before injury were less than \$241.79 per week, your TTD payments are the minimum: \$161.19 per week.
- If your date of injury is in 2015 and your gross wages before injury were less than \$248.24 per week, your TTD payments are the minimum: \$165.49 per week.
- If your date of injury is in 2016 and your gross wages before injury were less than \$253.89 per week, your TTD payments are the minimum: \$169.26 per week.

Particular example: A part-time nurse's aide was injured in 2015 and earned \$200.00 per week in gross wages before the injury. This worker receives TTD payments of \$165.49 per week.

What payments do I receive if I'm on TPD?

Your employer may offer you different work that you can do safely while recovering, or your employer may give you a reduced work schedule (see Chapter 6). If you don't earn as much as you did before you were injured, you may be eligible to receive temporary partial disability (TPD) payments. These are usually two-thirds of your lost wages.

Example: If the gross wages you were earning before you were injured were \$300 per week and you are now back at work making \$210 per week, your loss in wages is \$90 per week. Your TPD payments are \$60 per week (two-thirds of \$90).

As with TTD benefits, the law sets maximum limits and minimum amounts for TPD payments.

When do TD payments begin?

If your injury is covered by workers' compensation, your first TD payment is due within 14 days after your employer learns that:

- You have a job injury or illness;
and
- Your treating doctor says your injury prevents you from doing your job.

You should receive this payment from the claims administrator. The claims administrator must also send you a letter explaining how the payment amount was calculated.

After the first payment, TD benefits must be paid every two weeks, for as long as you are eligible.

Notices About TD Payments

The claims administrator must keep you up to date by sending letters that explain:

- How TD payment amounts were determined
- Reasons for delay or nonpayment of TD benefits
- Reasons for changes in TD payment amounts
- Why TD benefits are ending (with a list of all TD benefits paid).

What happens if I don't get my payments on time?

Sometimes payments are delayed. If the claims administrator can't determine whether your injury is covered by workers' compensation or whether TD benefits must be paid, 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 within the first 14 days
- What information the claims administrator needs in order to decide if you are eligible for TD benefits
- When a decision will be made.

If there are further delays, the claims administrator must send you additional delay letters. (Even if you received delay letters, if the claims administrator doesn't send you a letter *denying* your claim within 90 days after you filed the claim form or reported your injury, your claim is considered accepted in most cases.)

Is the claims administrator required to pay a penalty for delays in TD payments?

It depends. The claims administrator must pay you an additional 10 percent of the payment, if:

- The claims administrator sends a payment late;
and
- You filed a claim form for your injury more than 14 days before the payment was due.

This is true even if there was a reasonable excuse for the delay. However, there's no penalty if the claims administrator can't determine, in the first 14 days after your employer learned about your injury, whether TD benefits must be paid and sends you a delay letter as explained above.

You could be awarded a total of 25 percent of each late payment, up to \$10,000, if there was *no* reasonable excuse for the delay.

When do TD payments end?

TD payments end when:

- Your treating doctor says you can return to your usual job (whether or not you actually return to work); or
- You return to your usual job or to modified or alternate work at your regular wages (or at wages associated with a maximum limit on TTD payments); or
- You have reached a point where your condition is not improving and not getting worse (when this happens, your condition is called “permanent and stationary”); or
- You were injured on or after January 1, 2008, and received up to 104 weeks of TD benefits within five years from the date of injury, or you were injured sometime on or after April 19, 2004, through December 31, 2007, and received up to 104 weeks of TD benefits within two years from the start of payments. (Workers whose injuries involve acute and chronic hepatitis B, acute and chronic hepatitis C, amputations, severe burns, human immunodeficiency virus, high-velocity eye injuries, chemical burns to the eyes, pulmonary fibrosis, or chronic lung disease may receive up to 240 weeks of TD benefits within five years from the date of injury.)

When TD payments end, the claims administrator must send you a letter explaining why the payments are ending. The letter must list all TD payments sent to you. This letter must be sent within 14 days after your final TD payment.

If your treating doctor says that you will never recover completely, you may be eligible to receive permanent disability benefits or a supplemental job displacement benefit. See Chapters 7 and 8.

Temporary Total Disability Payments—Some Examples

OCCUPATION	DATE OF INJURY	GROSS WAGES BEFORE INJURY	TTD PAYMENTS	REASON
Carpenter	2014	\$1,650 per week	\$1,074.64 per week	This is the maximum for workers injured in 2014
Line Worker	2015	\$1,700 per week	\$1,103.29 per week	This is the maximum for workers injured in 2015
Secretary	2015	\$1,200 per week	\$800 per week	This is two-thirds of the wages earned before injury
Baker & Janitor (1 person with 2 jobs)	2015	\$620 per week (baker) \$280 per week (janitor) \$900 per week total	\$600 per week (if the injury was caused by the higher paying job)	This is two-thirds of the wages from both jobs combined
Truck Driver	2016	\$1,300 per week	\$866.67 per week	This is two-thirds of the wages earned before injury
Accountant	2016	\$1,800 per week	\$1,128.43 per week	This is the maximum for workers injured in 2016

Chapter 6. Working for Your Employer After Injury



For tips on how to keep your claim on track, see p. 9. See also Chapter 10.

After a job injury, staying at work or returning to work safely and promptly can help in your recovery. It can also help you avoid financial losses from being off work. This chapter describes how you can continue working for your employer.

Can I stay at work or return to work, and what work can I do?

After you are hurt on the job, many people work with you to decide how you will stay at work or return to work and what work you will do. These people include:

- Your primary treating physician;
- Your employer (supervisors or others in management);
- The claims administrator;
- Your attorney, if you have one.

Sometimes doctors and claims administrators do not fully understand your job or other jobs that could be assigned to you. Therefore, it is important that everyone stay in close touch throughout the process. You (and your attorney, if you have one) should **actively** communicate with your primary treating physician, 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 that your employer could make available to you.

What happens while I am recovering?

Soon after your injury, the primary treating physician examines you and sends a report to the claims administrator about your medical condition. If the 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 should be based on full and accurate information from you and your employer about the activities and demands of your job. They are intended to protect you from further injury.

Example: No lifting over 50 pounds at any time. No lifting over 30 pounds more than 10 times per hour. No lifting over 30 pounds more than 15 minutes per hour.

- 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 doctor reports that you cannot work at all while recovering, you cannot be required to work.

To review the steps you can take if you disagree with a medical report, see Chapter 4, pp. 15-17 and 20.

If You Can Work *with Restrictions*

If your primary treating physician reports that you can stay at work or return to work with work restrictions, any work that your employer assigns must meet these restrictions. Your employer may, for example, change certain tasks, reduce your time on certain tasks, or provide helpful equipment. Or, your employer may say that work like this is not available—if this happens, you cannot be required to work.

If You Can Work *Without Restrictions*

If your primary treating physician reports that you can stay at work or return to your job without restrictions, your employer usually must give you the same job and pay that 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.

My employer assigned work that seems to violate my work restrictions. What can I do?

You should show the doctor’s work restrictions to your employer and discuss how the restrictions can be met. You don’t have to accept an assignment that does not meet the restrictions. If you refuse this kind of assignment, you should clearly explain to your employer how it fails to meet the restrictions. If possible, do this in writing.

If your employer takes or threatens action against you because you won’t accept this work assignment, this could be a violation of California Labor Code section 132a, which prohibits discrimination against injured workers.

If your employer cannot give you work that meets the work restrictions, the claims administrator must pay temporary total disability benefits (see Chapter 5).

If you have questions or need help, use the resources in Chapter 10. Don’t delay, because there are *deadlines* for taking action to protect your rights.

What happens if I don’t fully recover?

Your primary treating physician may determine that you will never be able to return to the same job or working conditions that 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.

To assist your primary treating physician, you and your employer or the claims administrator may jointly fill out a “Description of Employee’s Job Duties” on DWC AD form 10133.33. The doctor can then review what you wrote on the form to make an appropriate determination.

To review the steps you can take if you disagree with a medical report, see Chapter 4, pp. 15-17 and 20.

TD Benefits

If you lose wages while recovering, you may be eligible for temporary disability (TD) payments. To learn about these payments, see Chapter 5.

PD Benefits

If your primary treating physician reports that you will never recover completely, you may be eligible for permanent disability (PD) payments. To learn about these payments, see Chapter 7.

Can I return to work for my employer even if I don't fully recover?

It depends on whether your employer can offer you a suitable job. If not, you may be eligible for other benefits if you were injured in 2004 or later.

FOR DATES OF INJURY IN 2013 OR LATER

If Your Employer Offers You Work

If you were injured in 2013 or later and your employer can offer you work, the claims administrator must send you a "Notice of Offer of Regular, Modified, or Alternative Work" on DWC-AD form 10133.35. The claims administrator must send this to you within 60 days after the claims administrator learns you have a permanent partial disability that has become permanent and stationary, or "P&S" (see Chapter 7). Your primary treating physician or another physician who makes this determination must complete and send the claims administrator a report of your P&S status and work capacity on DWC-AD form 10133.36.

The offer must be for a job that you are able to perform. In addition, the job must:

- Meet the work restrictions in the doctor's report
- Last at least 12 months
- Be within a reasonable commuting distance of where you lived at the time of injury.

The offer could involve one of the following:

- **Regular work.** This is your usual job or position at the time of injury. It must pay the same wages and benefits that you were paid at the time of injury.
- **Modified work.** This is your old job with changes that meet the doctor's work restrictions. It must pay at least 85 percent of the wages and benefits that you were paid at the time of injury.

Examples: Changing certain tasks, reducing time on certain tasks, changing the workstation, providing helpful equipment, changing the work location.

- **Alternative work.** This is work that is different from your old job and meets the doctor's work restrictions. It must pay at least 85 percent of the wages and benefits that you were paid at the time of injury.

If your employer offers you work that meets all of the requirements described above:

- You 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 won't be required to offer you a supplemental job displacement benefit. This is true *whether or not* you accept the offer.

If Your Employer Doesn't Offer You Work

If you were injured in 2013 or later, your employer does not offer you modified or alternative work, and your injury causes permanent partial disability, the claims administrator must send you a supplemental job displacement benefit, or "voucher." Permanent disability is discussed in Chapter 7. Supplemental job displacement benefits are described in Chapter 8.

FOR DATES OF INJURY IN 2004 THROUGH 2012

If Your Employer Offers You Work

If you were injured sometime in 2004 through 2012 and your employer can offer you work, the claims administrator must send you a “Notice of Offer of Modified or Alternative Work” on DWC-AD form 10133.53. The claims administrator must send this to you within 30 days after your final TD payment.

The offer must be for a job that you are able to perform. In addition, the job must:

- Pay at least 85 percent of the wages and benefits that you were paid at the time of injury
- Meet the work restrictions in the doctor’s report
- Last at least 12 months
- Be within a reasonable commuting distance of where you lived at the time of injury.

The offer could involve one of the following:

- **Modified work.** This is your old job with changes that meet the doctor’s work restrictions.
Examples: Changing certain tasks, reducing time on certain tasks, changing the workstation, providing helpful equipment, changing the work location.
- **Alternative work.** This is work that is different from your old job and meets the doctor’s work restrictions.

If your employer offers you work that meets all of the requirements described above:

- You 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 won’t be required to offer you a supplemental job displacement benefit. This is true *whether or not* you accept the offer.

If Your Employer Doesn’t Offer You Work

If you were injured sometime in 2004 through 2012, your employer does not offer you modified or alternative work, you do not return to work for your employer within 60 days after your final TD payment, and your injury causes permanent partial disability, the claims administrator must send you a supplemental job displacement benefit, or “voucher.” Permanent disability is discussed in Chapter 7. Supplemental job displacement benefits are described in Chapter 8.

My employer will not offer or assign me the kind of work that I want. What can I do?

In some cases, the work assigned or offered to you may seem unfair, or your employer may not offer you any work at all. An employer, however, is not always required to offer you a job that you want. For example, there may not be any jobs you want that meet the doctor's work restrictions. Or your employer's decision may be justified by business realities.

On the other hand, if the reason your employer will not offer you the work you want is because you have a job injury or because you requested workers' compensation benefits, this could be a violation of California Labor Code section 132a. Similarly, if the reason your employer will not offer you the work you want is because you have a serious and permanent disability, even though you could do the job with a reasonable accommodation, this could be a violation of the federal Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA). (For information about the interplay between workers' compensation and disability rights laws, see *Helping Injured Employees Return to Work: Practical Guidance Under Workers' Compensation and Disability Rights Laws in California*, listed in Chapter 10.)

If you have questions or need help, use the resources in Chapter 10. Don't delay, because there are *deadlines* for taking action to protect your rights.

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Chapter 7. Permanent Disability Benefits

What are permanent disability benefits?

Most workers recover from their job injuries. But some continue to have problems. If your treating doctor says you will never recover completely or will always be limited in the work you can do, you may have a permanent disability. This means that you may be eligible for permanent disability (PD) benefits.

You don't have to lose your job to be eligible for PD benefits. On the other hand, if you lose income because of a permanent disability, PD benefits may not cover all the income lost.

What is a P&S report?

When you reach a point where your medical condition is not improving and not getting worse, your condition is called "permanent and stationary" (P&S). This is referred to as the point in time when you have reached maximal medical improvement (MMI). When this happens, your primary treating physician writes a P&S report.

The P&S report should describe:

- Specific medical problems, such as how much you can move the injured parts of your body and how much pain you have.
- Limits on the work you can do. These are called "work restrictions."
- Medical care that you may need in the future for your injury.
- Whether you are able to return to your old job.
- An estimate of how much your disability is caused by your job, compared to how much it is caused by other factors. (**Note:** You must answer questions from your treating doctor concerning other medical problems that may be causing your disability.)

Your primary treating physician sends the P&S report to the claims administrator.

Important! The P&S report will affect your future benefits. You have a right to receive a copy of it. Request in writing that the claims administrator or your doctor give you copies of all medical reports.

Your primary treating physician must use special language to describe your disability. This language affects your benefits. If you have questions, ask the doctor. Read the P&S report carefully, make sure it's complete, and see if you agree with the doctor's conclusions. Information that is incorrect or left out could result in loss of some benefits.



Other Benefits Besides PD

If you have a permanent disability, you may also be eligible to receive:

- Medical care for your injury, described later in this chapter.
- A supplemental job displacement benefit. To learn about this benefit, see Chapter 8.
- Other financial help, such as Social Security disability benefits and benefits offered by some employers and unions. To find out about these benefits, use the resources in Chapter 10.

I don't agree with the P&S report. What can I do?

Sometimes different doctors have different opinions about a worker's disability. You have a right to challenge the P&S report.

To review the steps you can take if you disagree with a medical report, see Chapter 4, pp. 15-17 and 20.

What is a rating?

A "rating" is a percentage that estimates how much your disability limits the kinds of work you can do or your ability to earn a living. It determines the amount of your PD benefits.

Ratings are based on several factors:

1. Your medical condition, as described in the P&S report or in a medical-legal report (medical-legal reports are described in Chapter 4, p. 17).
2. Your date of injury.
3. Your age when injured.
4. Your occupation (based on your job at the time of injury).
5. How much your disability is caused by your job, compared to how much it is caused by other factors. This is called "apportionment."
6. Multiplication by an adjustment factor:
 - If you were injured in 2013 or later, the adjustment factor is 1.4.
 - If you were injured before 2013 and your permanent disability is rated using the 2005 rating schedule (described in the box "Rating Schedules), the adjustment factor is based on your reduced "future earning capacity."

A rating of 100 percent means that you have a permanent *total* disability. Ratings of 100 percent are very rare. A rating between 1 percent and 99 percent means you have a permanent *partial* disability. Most injured workers do not have a permanent disability, and those who do usually have ratings between 5 percent and 30 percent (if injured before 2005).

Rating Schedules

The "Schedule for Rating Permanent Disabilities" is used to rate disabilities based on the factors listed above. There are three schedules:

- 1. 2005 rating schedule.** If you were injured in 2005 or later, the 2005 rating schedule applies to you.
- 2. 2005 or 1997 rating schedule.** If you were injured between April 1997 and December 2004 and, prior to 2005, there was no comprehensive medical-legal report or no report by a treating physician indicating that you had a permanent disability, or your employer was not required to send you a notice about PD benefits, then the 2005 rating schedule applies to you. Otherwise, the 1997 rating schedule applies to you.
- 3. 1988 rating schedule.** If you were injured before April 1997, in most cases the 1988 rating schedule applies to you.

To see the schedules, contact an Information & Assistance officer (see pp. 48–49). To view the schedules, go to the Division of Workers' Compensation website: www.dir.ca.gov/dwc/dwcrep.htm.

Examples of Permanent Disability Ratings

These examples are not adjusted for age, occupation, or other factors causing the disability (apportionment).

DISABILITY	INJURY IN 2005-2012	INJURY IN 2013 OR LATER
Total loss of vision in one eye, normal vision (20/20) in other eye	22% (adjusted for reduced "future earning capacity")	28% (adjusted by factor of 1.4)
Amputation of index finger at middle joint	9% (adjusted for reduced "future earning capacity")	11% (adjusted by factor of 1.4)

How is my disability rated?

The P&S report is the first major step in the rating process:

- If the 2005 rating schedule applies to you (see "Rating Schedules" box on p. 32), when your treating doctor writes the P&S report, he or she must rate your "impairment," or how much you have lost the normal use of injured parts of your body. The doctor's methods for rating your impairment must follow guidelines published by the American Medical Association (AMA).
- If one of the earlier rating schedules applies to you, your treating doctor is not required to rate your impairment in the P&S report. Instead, the doctor must describe your disability according to factors listed in the rating schedule that applies to you.

To review the steps you can take if you disagree with a medical report, see Chapter 4, pp. 15-17 and 20.

Next, you, your attorney, or the claims administrator can ask a disability rater to rate your disability based on the P&S report. (If you were examined by a QME and don't have an attorney, a disability rater will automatically rate your disability.) Also, the claims administrator and your attorney may each try to predict a rating that a workers' compensation judge would consider appropriate.

I disagree with the rating by the claims administrator. What can I do?

You have a right to challenge the rating. Different people reviewing the same medical report will sometimes rate a worker's disability differently.

You or your attorney (if you have one) can negotiate with the claims administrator over the correct rating of your disability. You can request a rating by a disability rater and use this rating in your negotiations.

If you and the claims administrator can't agree on the rating of your disability, you can request that a workers' compensation judge decide on the correct rating.

I disagree with the rating by the disability rater. What can I do?

If you don't have an attorney, you can ask the administrative director of the Division of Workers' Compensation (DWC) to 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 judge.

To get help in requesting reconsideration or presenting your case to a workers' compensation judge, contact an Information & Assistance officer (see pp. 48–49). Ask about possible delays in the reconsideration process.

If you have an attorney, he or she can present your case to a workers' compensation judge.

How are PD payments determined?

PD benefit amounts are set by law. The claims administrator will determine how much to pay you based on several factors:

1. Rating(s) of your disability.
2. Your date of injury.
3. Your wages before you were injured.
4. Whether or not your employer offers you work meeting the requirements listed on p. 36. See "How are my PD payments affected if my employer does or doesn't offer me work?"

Examples of Permanent Disability Benefits

These examples are based on ratings, shown on p. 33, that were not adjusted for age, occupation, or other factors causing disability (apportionment). They apply to workers who earned more than \$435 per week before the injury and whose employer has fewer than 50 employees.

DISABILITY	INJURY IN 2005-12	INJURY IN 2013	INJURY IN 2014
Total loss of vision in one eye, normal vision (20/20) in other eye	\$19,665.00 (total)	\$27,312.50 (total)	\$34,437.50 (total)
Amputation of index finger at middle joint	\$6,210.00 (total)	\$7,877.50 (total)	\$9,932.50 (total)

Notices about PD payments

The claims administrator must keep you up to date by sending letters that explain:

- How PD payments were determined
- When you will receive PD payments
- Reasons for delay or nonpayment of PD benefits
- Reasons for changes in PD benefit amounts
- Why PD benefits are ending (with a list of all PD benefits paid).

When do I receive PD payments?

If you have a permanent *partial* disability, you are eligible to receive the total amount of your PD benefits spread over a fixed number of weeks. If you have a permanent *total* disability, you are eligible to receive PD payments for the rest of your life.

PD payments are due as listed below, except as follows: If your employer offers you work that pays at least 85 percent of the wages and benefits that you were paid at the time of injury or you are working in a job that pays at least 100 percent of the wages and benefits that you were paid at the time of injury, you will not receive PD payments until after a workers' compensation judge approves a settlement of your case or decides on the PD benefits you will receive. If neither of the above is true:

- If you were receiving temporary disability (TD) benefits, the first PD payment is due within 14 days after the final TD payment.
- If you weren't receiving TD benefits, you should receive the first PD payment within 14 days after the claims administrator learns that you have a permanent disability caused by your injury. After the first payment, PD benefits must be paid every 14 days.

PD payments end when you reach the maximum amount allowed by law or when you settle your case and receive a lump sum. **Note:** This lump sum is reduced by the PD benefits that you already received, including any lump sum advances.

How are my PD payments affected if my employer does or doesn't offer me work?

Note: This question only affects workers who were injured sometime in 2005 through 2012 and whose employers have 50 or more employees. If you were injured in 2013 or later, or if your employer has fewer than 50 employees, your PD payments are not affected by whether your employer offers you work.

If your employer offers you regular, modified, or alternative work meeting the requirements listed below, your PD payments decrease by 15 percent starting on the date you receive the offer. If your employer does not make this offer, your PD payments increase by 15 percent starting 60 days after your condition becomes permanent and stationary.

- To offer regular work, your employer or the claims administrator must send you a “Notice of Offer of Regular Work” (on form DWC-AD 10118) within 60 days after your condition becomes permanent and stationary. The work must:
 - Pay the same wages and benefits as your old job
 - Meet the work restrictions in the doctor’s report
 - Last at least 12 months
 - Be within a reasonable commuting distance of where you lived at the time of injury.
- To offer modified or alternative work, your employer or the claims administrator must send you a “Notice of Offer of Modified or Alternative Work” (on form DWC-AD 10133.53) within 60 days after your condition becomes permanent and stationary. The work must:
 - Pay at least 85 percent of the wages and benefits you were receiving at the time of injury
 - Meet the work restrictions in the doctor’s report
 - Last at least 12 months
 - Be within a reasonable commuting distance of where you lived at the time of injury.

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

Yes. If the claims administrator sends a payment late, he or she must pay you an additional 10 percent of the payment.

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. (Note, however, that this penalty is not required if you did not file a claim form for your injury.)

You could be awarded a total of 25 percent of each late payment, up to \$10,000, if there was no reasonable excuse for the delay.

Can my case be settled?

Yes. After your disability is rated, the claims administrator may offer to settle your case. A settlement is an agreement between you and the claims administrator. There are two different ways to settle your case:

1. Stipulations with Request for Award (“Stips”)

- **Payments.** You and the claims administrator agree on when and how long you’ll continue to receive PD payments. You also agree on how much each payment will be.
- **Medical care.** The claims administrator usually agrees to keep paying for medical care for your injury, as long as care is needed. **Note:** Medical treatment guidelines for treating job injuries are described in Chapter 3 (see “What kind of medical care is available to injured workers?”). They can be used even if your case settled before the guidelines were added to workers’ compensation law in 2003.
- **Possible changes in benefits.** If your condition gets worse, you have a right to request additional workers’ compensation benefits. Similarly, if your condition improves, the claims administrator has a right to request that the benefits be reduced. Usually a request for increase or decrease in benefits must be made within five years after the date of your injury.

2. Compromise and Release (C&R)

- **One payment.** The claims administrator agrees to pay you a lump sum. This covers the PD payments you haven’t received yet.
- **Medical care.** If the lump sum (above) covers the estimated cost of future medical care, the claims administrator will no longer pay your doctor. This becomes your responsibility.
- **No changes in benefits.** You don’t have the right to request additional workers’ compensation benefits if your condition gets worse. Similarly, the claims administrator doesn’t have the right to request that your benefits be reduced if your condition improves.

If you and the claims administrator agree on a settlement, a workers’ compensation judge must review it to determine whether it is adequate.

What if I don’t agree with the claims administrator’s settlement offers?

You are not required to accept the claims administrator’s offers. You can negotiate a settlement. If you can’t reach an agreement with the claims administrator, you can present your case to a workers’ compensation judge. The judge will decide what benefits you will receive. This decision is called a Findings and Award. It will be sent to you in writing.

Negotiating a settlement or presenting your case to a workers’ compensation judge can be difficult. To get help, use the resources in Chapter 10.



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Chapter 8. Supplemental Job Displacement Benefits



For tips on how to keep your claim on track, see p. 9. See also Chapter 10.

If you were injured in 2004 or later and you have a permanent partial disability, you may be eligible to receive a supplemental job displacement benefit (SJDB).

The type of SJDB you may receive and the procedures to obtain this benefit depend on your date of injury and whether your employer offers you suitable work (as described in Chapter 6). The first section of this chapter describes the benefit that is available to workers injured in 2013 or later. The second section describes the benefit that is available to workers injured in 2004-2012.

IF YOU WERE INJURED IN 2013 OR LATER

What is a supplemental job displacement benefit?

A supplemental job displacement benefit is a voucher that promises to help pay for educational retraining or skill enhancement, or both, at eligible schools. You can use the voucher to pay for tuition, fees, books, tools, or other expenses required by the school for retraining or skill enhancement, and for licensing or professional certification fees, related examination fees, and examination preparation course fees.

Up to \$600 of the voucher money may be used to pay for services of a licensed placement agency, a vocational or return-to-work counselor (a person who helps injured workers develop their goals and plans for returning to work), and resumé preparation.

Up to \$1,000 may be used to purchase computer equipment.

Up to \$500 of the voucher money may be used upon request for miscellaneous expenses without receipts or other documentation.

What is the dollar amount of this benefit?

The voucher is redeemable up to \$6,000, regardless of your permanent disability rating. You cannot redeem the voucher as part of a settlement of your case.

How can I obtain this benefit?

The claims administrator must offer you a supplemental job displacement benefit if the following are true:

- Your injury causes permanent partial disability.
- Your employer does not offer you regular, modified, or alternative work within 60 days after the claims administrator receives the “Physician’s Return-to-Work & Voucher Report” described in Chapter 6.

The claims administrator sends the voucher on a form called “Supplemental Job Displacement Non-Transferable Voucher Form” (DWC-AD 10133.32).

When do I receive the voucher?

The claims administrator must offer you the voucher within 20 days after the end of the period when your employer may offer you regular, modified, or alternative work (see previous section).

What schools can I attend?

The voucher helps pay for you to attend a California public school or receive training with a provider on the state's Eligible Training Provider List (ETPL). This list is posted on the website of the Employment Development Department: www.edd.ca.gov/jobs_and_training/Eligible_Training_Provider_List.htm.

What vocational or return-to-work counselors can I use?

The Division of Workers' Compensation maintains a list of qualified vocational and return-to-work counselors. To see the list, contact an Information & Assistance officer (see pp. 48–49). See also the DWC website: www.dwc.ca.gov.

How do I use the voucher to pay for expenses?

If you present the voucher to the school and counselor you select, they can contact the claims administrator for direct payment. If you pay the expenses directly and submit receipts to the claims administrator, the claims administrator reimburses you. He or she must do this within 45 days after receiving the receipts along with your signed voucher.

Is there a deadline for using the voucher?

Yes. The voucher expires two years after the date the voucher is furnished to you, or five years after your date of injury, whichever is later. All expenses must be incurred and submitted with required receipts and other documentation before the expiration date.

I have a problem with my supplemental job displacement benefit.

What can I do?

You can contact your employer, the claims administrator, an Information & Assistance officer, an attorney, or your union (if you have one). These resources are described in Chapter 10. Don't delay, because there are *deadlines* for taking action to protect your rights.

IF YOU WERE INJURED IN 2004-2012

What is a supplemental job displacement benefit?

A supplemental job displacement benefit is a voucher that promises to help pay for educational retraining or skill enhancement, or both, at state-approved or state-accredited schools. You can use the voucher to pay for tuition, fees, books, or other expenses required by the school for retraining or skill enhancement. Up to 10 percent of the voucher money may be used to pay for services of a vocational or return-to-work counselor, a person who helps injured workers develop their goals and plans for returning to work.

What is the dollar amount of this benefit?

The amount depends on the rating that a workers' compensation judge considers appropriate for your permanent disability. The judge makes this determination when reviewing a settlement of your case or when issuing a Findings and Award in your case. For more information about permanent disability ratings, see Chapter 7.

The dollar amounts of vouchers are as follows:

- Up to \$4,000 for permanent disability ratings less than 15 percent
- Up to \$6,000 for permanent disability ratings between 15 and 25 percent
- Up to \$8,000 for permanent disability ratings between 26 and 49 percent
- Up to \$10,000 for permanent disability ratings between 50 and 99 percent

How can I obtain this benefit?

The claims administrator must send you a supplemental job displacement benefit if the following are true:

- Your employer does not offer you modified or alternative work within 30 days after your final temporary disability (TD) payment;
- You do not return to work for your employer within 60 days after that payment; and
- Your injury causes permanent partial disability.

The claims administrator sends the voucher on a form called "Supplemental Job Displacement Nontransferable Training Voucher Form" (DWC-AD 10133.57).

When do I receive the voucher?

The claims administrator must send you the voucher within 25 days after a workers' compensation judge issues an award for permanent partial disability.

What schools can I attend?

The voucher helps pay for you to attend a state-approved or state-accredited school. This can be a California community college, a California state university, or the University of California.

Or it can be a private school that is:

- Accredited by one of the regional associations of schools and colleges authorized by the US Department of Education; or
- Approved by the California Bureau for Private Postsecondary Education; or
- Certified by the Federal Aviation Administration.

What vocational or return-to-work counselors can I use?

The Division of Workers' Compensation maintains a list of qualified vocational and return-to-work counselors. To see the list, contact an Information & Assistance officer (see pp. 48–49). See also the DWC website: www.dwc.ca.gov.

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How do I use the voucher to pay for expenses?

If you present the voucher to the school and counselor you select, they can contact the claims administrator for direct payment. If you pay the expenses directly and submit receipts to the claims administrator, the claims administrator reimburses you. He or she must do this within 45 days after receiving the receipts along with your signed voucher.

Is there a deadline for using the voucher?

Yes. Vouchers issued in 2013 or later expire two years after the date the voucher is furnished to you, or five years after your date of injury, whichever is later. All expenses must be incurred and submitted with required receipts and other documentation before the expiration date.

Vouchers issued before 2013 do not have an expiration date.

I have a problem with my supplemental job displacement benefit. What can I do?

You can contact your employer, the claims administrator, an Information & Assistance officer, an attorney, or your union (if you have one). These resources are described in Chapter 10. Don't delay, because there are *deadlines* for taking action to protect your rights.

Chapter 9. Return-to-Work Supplement Program



For information on the SJDB, see Chapter 8.

The Return-to-Work Supplement Program (RTWSP), administered by the Department of Industrial Relations, was created in April 2015 for the purpose of making a one-time supplemental payment to workers who experience a disproportionate loss of earnings.

Who is eligible for a Return-to-Work Supplement?

You may be eligible for a Return-to-Work Supplement if you have a date of injury on or after January 1, 2013, and have received a Supplemental Job Displacement Benefit (SJDB) voucher for that injury.

What is the deadline for applying?

The application for the supplemental benefit must be received by the RTWSP within one year of the date the SJDB voucher was served on the applicant or within one year from April 13, 2015, the implementation date of the regulations, whichever is later.

What is the dollar amount of the Return-to-Work Supplement?

A one-time \$5,000 Return-to-Work supplement is issued to an injured worker who meets the eligibility criteria.

How do I apply for the supplement?

The RTWSP application is only available online at <https://www.dir.ca.gov/RTWSP/RTWSPApplication.html>.

If you do not have access to a computer, every DWC district office has a kiosk near the Information and Assistance office, equipped with a computer, scanner, and printer for your use.

What information will I need to complete an application (other than name, address, and phone number)?

- Social Security or tax ID number.
- SJDB voucher or SJDB voucher proof of service.
 - The SJDB voucher must be in pdf or tiff format for uploading and attaching to the online application.
- Adjudication number (sometimes called “ADJ number”).
 - The ADJ number can be found on most documents filed with the DWC. You can also look up your ADJ number by using the EAMS search function (<https://eams.dwc.ca.gov/WebEnhancement/>) or you can contact the nearest Information and Assistance office for help.
- Workers’ compensation claim number
 - The claim number can be found on any document received from your claims adjuster or insurance carrier.
- Instructions for completing the application, available in English and Spanish at www.dir.ca.gov/RTWSP/RTWSP.html.

What happens after I submit my application?

The RTWSP will review completed applications within 60 days from the date of filing. If you are deemed eligible for the supplement, payment will be issued within 25 days of the eligibility determination.

What if I disagree with the RTWSP’s eligibility decision?

If you disagree with the final eligibility decision, you may appeal to the WCAB within 20 days of the service of the eligibility decision by filing a Petition for Reconsideration and serving a copy of the petition on the RTWSP at 1515 Clay St., 17th Floor, Oakland, CA 94612.

For further assistance, you may contact the RTWSP staff at rtwsp@dir.ca.gov or by calling 510-286-0787, Monday through Friday, 8:00 a.m.–5:00 p.m. PST.

Chapter 10. For More Information and Help



For tips on how to keep your claim on track, see p. 9.

Your Employer

Your employer is required to post information and give you written materials that explain workers' compensation. If you have questions, you can contact your supervisor, someone else in management, or your employer's personnel or benefits department.

The Claims Administrator

This person handles workers' compensation claims for your employer. Most claims administrators work for insurance companies or other organizations that handle claims for employers. Some claims administrators work directly for large employers that handle their own claims. This person may also be called a claims examiner or claims adjuster. The claims administrator is required to send you written information about your claim and may answer questions. If you can't reach the claims administrator, ask to speak with his or her supervisor.

Division of Workers' Compensation

DWC administers workers' compensation laws and provides information and help to injured workers. Check the Government Pages at the front of the white pages of a phone book. Look under: State Government Offices/Industrial Relations. See also the DWC website: www.dwc.ca.gov.

Information & Assistance. I&A officers answer questions and help injured workers resolve problems with their claims. Their services are free. For more information, see "Questions and Answers About Information & Assistance Services" on p. 48.

Medical Unit. This unit oversees medical provider networks (MPNs), independent medical review when an injured worker disagrees with MPN doctors, health care organizations (HCOs), qualified medical evaluators (QMEs), utilization review (UR) plans, and independent medical review (IMR) when an injured worker disagrees with a decision to deny treatment recommended by a treating physician. For information or to report a problem, call toll-free: 1-800-794-6900 or 1-800-999-1041. See also the Medical Unit website: www.dir.ca.gov/dwc/MedicalUnit/imchp.html.

Workers' Compensation Appeals Board. This is where workers' compensation judges hear cases and decide on problems and disputes. If a problem can't be resolved through discussions with the claims administrator, an I&A officer can help you request a hearing before a workers' compensation judge, or an attorney can request a hearing and represent you before the judge. If you disagree with a decision of a workers' compensation judge, you can request reconsideration of the judge's decision by a seven-member Appeals Board.

Commission on Health and Safety and Workers' Compensation (CHSWC)

CHSWC conducts ongoing studies and makes recommendations to improve the workers' compensation system and the state's activities to prevent job injuries. Studies, reports, and issues papers are posted online at the CHSWC website: www.dir.ca.gov/chswc/.

Applicants' Attorneys

These are lawyers who represent injured workers in their workers' compensation cases. For more information, see "Questions & Answers About Attorneys" on p. 50.

Your Primary Treating Physician

You can ask your treating doctor about the kind of medical care you need, the kind of work you can do while recovering, and whether you'll have a permanent disability. You can also ask your primary treating physician and any specialists you see for copies of all medical reports that he or she sends to the claims administrator.

Labor Organizations

Your union may help resolve problems with your workers' compensation claim, tell you about other benefits, negotiate changes needed in your job, protect you from discrimination, and refer you to legal services. You can also seek help from a central labor council or building trades council in your area.

Occupational Health Clinics

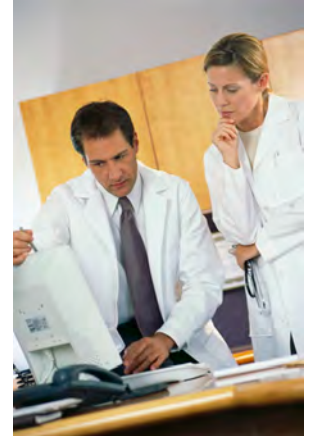
Doctors at occupational health clinics specialize in work-related injuries and illnesses. For information about occupational health clinics, call the Association of Occupational and Environmental Clinics (AOEC) at 1-888-347-2632, or ask your personal physician or health plan. See also the AOEC website: www.aoec.org.

Health & Safety Agencies & Organizations

For help with health or safety hazards at work:

California Division of Occupational Safety and Health (Cal/OSHA). Check the Government Pages at the front of the white pages of a phone book. Look up: State Government Offices/Industrial Relations/Occupational Safety & Health. Cal/OSHA takes worker complaints, inspects workplaces, and enforces health and safety laws. See also the Cal/OSHA website: www.dir.ca.gov/dosh/.

Labor Occupational Health Program (LOHP), University of California at Berkeley (phone: 1-510-642-5507; website: www.lohp.org). Offers information, training, and help on health and safety matters, including workers' compensation. Serves workers, unions, and others in California and nationwide.





Labor Occupational Safety and Health Program (LOSH), University of California at Los Angeles (phone: 1-310-794-5964; website: www.losh.ucla.edu). Offers information, training, and help on health and safety matters, including workers' compensation. Serves workers, unions, and others in California and nationwide.

Other State and Federal Agencies—Financial Assistance

California Employment Development Department (EDD) (phone: 1-800-480-3287; 1-800-333-4606). For a local office, check the Government Pages at the front of the white pages of a phone book. Look under: State Government Offices. EDD gives information on State Disability Insurance (SDI) and unemployment insurance (UI) benefits. See also the EDD website: www.edd.ca.gov.

US Social Security Administration (SSA) (phone: 1-800-772-1213). For a local office, check the Government Pages at the front of the white pages of a phone book. Look under: United States Government Offices. SSA gives information on Social Security disability benefits and other benefits. See also the SSA website: www.ssa.gov.

Other State and Federal Agencies—Discrimination Complaints

Workers' compensation law. If you face discrimination for filing a workers' compensation claim or for having a job injury, you can contact an Information & Assistance officer, an applicants' attorney, or your union (if you have one).

Disability rights laws. If you face discrimination because of a permanent disability or other medical condition, you can contact an attorney who specializes in employment law. You can get names of attorneys from a local bar association, a county legal aid society, your union (if you have one), or other injured workers. You can also contact the State Bar of California about lawyer referral services (phone toll-free: 1-866-442-2529; website: www.calbar.ca.gov), or check the yellow pages of a phone book and look under: *Attorney Referral Service*. You can also ask for help from these agencies:

- **US Equal Employment Opportunity Commission (EEOC)** (phone: 1-800-669-4000). For a local office, check the Government Pages at the front of the white pages of a phone book. Look under: United States Government Offices/Discrimination. See also the EEOC website: www.eeoc.gov.
- **California Department of Fair Employment and Housing** (phone: 1-800-884-1684). For a local office, check the Government Pages at the front of the white pages of a phone book. Look under: State Government Offices. See also the DFEH website: www.dfeh.ca.gov.

Books and Other Materials



Schedule for Rating Permanent Disabilities. This state publication is used to rate permanent disabilities. There are three schedules, depending on your date of injury and the particular stage of your claim. To see the schedule that applies to you, contact an Information & Assistance officer (see pp. 48–49), or go to the Division of Workers’ Compensation website: <http://www.dir.ca.gov/dwc/dwcrep.htm>.

If Your Employer Is Illegally Uninsured: How to Apply for Workers’ Compensation Benefits (2011) and **Si su Empleador se Encuentra Ilegalmente Sin Seguro: Cómo Solicitar los Beneficios de Compensación del Trabajador (2011)**, prepared by UC Berkeley’s Institute for Research on Labor and Employment. A booklet in English and Spanish for workers in California whose employers are illegally uninsured for workers’ compensation. This booklet discusses 10 basic steps to apply for benefits from the state Uninsured Employers Benefits Trust Fund if the employer does not pay those benefits. For a free copy, contact the Commission on Health and Safety and Workers’ Compensation (phone: 1-510-622-3959; website: www.dir.ca.gov/chswc/).

California Workers’ Comp: How to Take Charge When You’re Injured on the Job, 10th Edition (May 2014), by Christopher A. Ball. A detailed guide for workers, available in bookstores or from Nolo Press (website: www.nolo.com).

California Workers’ Compensation Practice, 5th Edition (updated July 2015), Continuing Education of the Bar, California. A comprehensive reference for attorneys, available in law libraries (website: www.ceb.com).

Helping Injured Employees Return to Work: Practical Guidance Under Workers’ Compensation and Disability Rights Laws in California (February 2010), prepared by UC Berkeley’s Institute for Research on Labor and Employment. For small employers, this handbook describes how to establish and implement an effective return-to-work program, coordinate return-to-work with workers’ compensation benefits, and ultimately strengthen the work environment and overall health of a company or organization. For employees, it describes everyone’s roles and responsibilities and what can be expected in the process. For a free copy, contact the Commission on Health and Safety and Workers’ Compensation (phone: 1-510-622-3959; website: www.dir.ca.gov/chswc/).

How to Create a Workers’ Compensation Carve-Out in California: Practical Advice for Unions and Employers (2006). A booklet for labor unions and employers that would like to “carve out” an alternative system for delivering benefits to injured workers and resolving problems and disputes, prepared by UC Berkeley’s Institute of Industrial Relations and Labor Occupational Health Program. For a free copy, contact the Commission on Health and Safety and Workers’ Compensation (phone: 1-510-622-3959; website: www.dir.ca.gov/chswc/).

Navigating the California Workers’ Compensation System (1996). A report of injured workers’ experiences, prepared by UC Berkeley’s Labor Occupational Health Program. For a free copy, contact the Commission on Health and Safety and Workers’ Compensation (phone: 1-510-622-3959; website: www.dir.ca.gov/chswc/).

Questions & Answers About Information & Assistance Services

Q. How can I&A officers help me?

- A. I&A officers can give you fact sheets, workers' compensation forms, and guides that explain how to fill out the forms. The fact sheets and guides include:

Fact sheet for injured workers: Basic facts on workers' compensation for injured workers

Fact sheet A: Answers to your questions about utilization review

Fact sheet B: Glossary of workers' compensation terms for injured workers

Fact sheet C: Answers to your questions about temporary disability benefits

Fact sheet D: Answers to your questions about permanent disability benefits

Fact sheet E: Answers to your questions about qualified medical evaluators and agreed medical evaluators

Fact sheet F: Answers to your questions about the state's Uninsured Employers Benefits Trust Fund

I&A guide 1: How to file a workers' compensation claim form

I&A guide 2: How to request a qualified medical evaluation

I&A guide 3: How to object to your summary rating

I&A guide 4: How to file an application for adjudication of claim

I&A guide 5: How to file a declaration of readiness to proceed

I&A guide 6: How to request an expedited hearing

I&A guide 7: How to file a petition for discrimination (Labor Code 132a)

I&A guide 8: How to file a serious and willful misconduct petition

I&A guide 9: How to file a petition for commutation

I&A guide 10: How to file a lien

I&A guide 11: How to file a petition to reopen

I&A guide 12: How to file a petition for reconsideration

I&A guide 13: How to file an appeal of the administrative director

I&A guide 14: How to file a complaint with the Audit Unit

I&A guide 15: How to dismiss your attorney

I&A guide 16: How to file a claim with the Uninsured Employers Benefits Trust Fund

I&A guide 16A: How to correctly name your employer for the Uninsured Employers Benefits Trust Fund

I&A guide 16B: How to serve your employer in an Uninsured Employers Benefits Trust Fund case

I&A guide 17: How to complete a document cover sheet

I&A guide 18: How to complete a document separator sheet

I&A officers:

- May answer questions about your claim. Help is available in several languages.
- May call the claims administrator to help clear up misunderstandings.
- May hold meetings to resolve problems or disputes.
- Cannot actively prepare your case, argue on your behalf, or speak as your representative (unlike an attorney).

Q. How can I contact an I&A officer?

- A. To contact an I&A officer:

- Call toll-free (phone: 1-800-736-7401) to hear recorded messages or request written materials.
- Attend a free, one-hour I&A workshop (designed mostly for injured workers who do not have attorneys and whose cases have been accepted).
- Call a local I&A officer at an office listed on the next page.

Division of Workers' Compensation (DWC) Information & Assistance Offices

Information & Assistance (I&A) officers answer questions and help injured workers; their services are free. (The numbers listed below were effective as of April 2016.)

To hear recorded messages, call toll-free: 1-800-736-7401.

District Offices

Anaheim.....	1-714-414-1801
Bakersfield.....	1-661-395-2514
Eureka	1-707-441-5723
Fresno	1-559-445-5355
Long Beach.....	1-562-590-5240
Los Angeles	1-213-576-7389
Marina del Rey.....	1-310-482-3820
Oakland.....	1-510-622-2861
Oxnard.....	1-805-485-3528
Pomona	1-909-623-8568
Redding	1-530-225-2047
Riverside.....	1-951-782-4347
Sacramento.....	1-916-928-3158
Salinas	1-831-443-3058
San Bernardino	1-909-383-4522
San Diego	1-619-767-2082
San Francisco	1-415-703-5020
San Jose.....	1-408-277-1292
San Luis Obispo.....	1-805-596-4159
Santa Ana	1-714-558-4597
Santa Barbara.....	1-805-884-1988
Santa Rosa.....	1-707-576-2452
Stockton	1-209-948-7980
Van Nuys	1-818-901-5367

For district office addresses, check the Government Pages at the front of the white pages of your phone book. Look under "State Government Offices/Industrial Relations/Workers' Compensation."

See also the DWC website, www.dwc.ca.gov.

Questions & Answers About Attorneys



Q. How can an attorney help me?

A. The job of an applicants' attorney is to:

- Protect your rights.
- Plan a strategy for your case to obtain all the benefits owed to you.
- Be your advocate.
- Gather information to support your claim.
- Keep track of deadlines.
- Represent you in hearings before a workers' compensation judge.
- Tell you about additional claims and benefits that may be available.

Q. How are attorneys paid?

A. Most applicants' attorneys provide one free consultation. If you hire an attorney, you don't pay right away. Instead, the attorney's fee is taken out of some of your benefits later. The fee is usually 9 to 15 percent of your final permanent disability settlement or award. A workers' compensation judge must approve the fee.

Note: Often applicants' attorneys will not take cases where the worker does not have a permanent disability.

Q. When do I need an attorney?

A. You may need an attorney if:

- You believe your employer or the claims administrator is treating you unfairly or withholding benefits; or
- You have a permanent disability that limits you or causes pain; or
- You're not sure how to proceed with your case, and no one else will help.

Q. What are possible drawbacks of hiring an attorney?

A. The attorney's fee will be taken out of your benefits. Also, other people involved in your case may be allowed to speak only with your attorney on important matters, and cannot speak directly with you.

Q. How do I choose an attorney?

A. Choose one with experience in workers' compensation, preferably one who is certified by the State Bar of California as a workers' compensation specialist. You can get names of applicants' attorneys from the State Bar of California (phone: 1-415-538-2120; website: www.calbar.ca.gov), a local bar association, the California Applicants' Attorneys Association (phone: 1-800-648-3132 within California; website: www.caaa.org), a county legal aid society, your union (if you have one), or other injured workers.

Choose carefully. In your first meeting, see how well the attorney and his or her staff communicate with you. If you hire an attorney and then later want to switch, it may be difficult to find another attorney to take your case.

Choose carefully. If you hire an attorney and then later want to switch, it may be difficult to find another attorney to take your case.

Appendix A. Important Laws & Regulations

Laws and regulations that govern your rights and obligations in the California workers' compensation system are listed below.

To access the laws, go to <https://leginfo.legislature.ca.gov/faces/codes/xhtmll>.

To access the regulations, go to <https://govt.westlaw.com/calregs/>. You can then access a specific regulatory section by using the search function at the top right-hand corner, which is indicated by a magnifying glass icon. Click on the icon and enter Title 8 and the section number you are searching for.

Caution: Some rules are based on legal interpretations found in case law and are not spelled out in statutes and regulations. Case law includes past decisions of workers' compensation judges, the Appeals Board, and state courts. If you have questions, use the resources in Chapter 8.

Introduction

Labor-management carve-out agreements: Labor Code sections 3201.5 to 3201.9; Title 8 regulations, sections 10200 to 10204

Chapter 1

Definitions of "injury": Labor Code sections 3208, 3208.5, and 3208.1

Limitations on coverage for psychiatric injuries: Labor Code section 3208.3

Limitations on coverage for injuries reported after notice of termination or layoff: Labor Code section 3600(a)(10)

Medical care benefits: Labor Code section 4600

Temporary disability (TD) and permanent disability (PD) benefits: Labor Code sections 4453 to 4459, 4650, 4658.1, and 4659 to 4664

Supplemental job displacement benefits: Labor Code sections 4658.5, 4658.6, and 4658.7

Death benefits: Labor Code sections 4700 to 4728

Pre-designating your personal physician or a medical group: Labor Code sections 3551(b)(3) and 4600(d); Title 8 regulations, sections 9780(f), 9780.1, and 9783

Pre-designating your personal physician if employer or insurer has a contract with an HCO: Labor Code sections 3551(b)(3) and 4600.3(a); Title 8 regulations, sections 9779.3 to 9779.4

Reporting your injury or illness to your employer: Labor Code sections 5400, 5402(a)

Illegal to discriminate against (punish or fire) an injured worker because of the injury: Labor Code section 132a

Employer must ensure access to emergency medical services: Title 8 regulations, section 3400

Injury and Illness Prevention Program: Labor Code section 6401.7; Title 8 regulations, section 3203

Medical care as a workers' compensation benefit regardless of time lost: Labor Code section 4600(a)

Limitations on coverage for residential employees who are temporary or part-time: Labor Code sections 3352(h) and 3715(b)

Definition of "independent contractor": Labor Code section 3353



To access the laws, go to <https://leginfo.legislature.ca.gov/faces/codes/xhtmll> and link to California Law.

To access the regulations, go to <https://govt.westlaw.com/calregs/> and link to the California Code of Regulations.

Coverage for aliens (immigrants): Labor Code section 3351(a)

Workers' compensation benefits regardless of who was at fault for your injury: Labor Code section 3600(a)

Cannot sue your employer for a job injury; exceptions: Labor Code sections 3602, 3706, and 4558

Chapter 2

Employer must give or mail claim form within one working day after learning about injury: Labor Code section 5401(a); Title 8 regulations, sections 10136 to 10139

Role of the primary treating physician: Labor Code section 4061.5; Title 8 regulations, sections 9785 to 9785.4, and 10133.36

Employer must forward completed claim form to claims administrator and give injured worker a copy: Title 8 regulations, section 10140(a)

Claims administrator must accept or deny new claim within a reasonable time: Labor Code sections 5814 and 5814.6; Title 8 regulations, section 10109

Notices denying or delaying a claim: Title 8 regulations, section 9812(i) and (j)

Workers' compensation fraud: Labor Code sections 3820 to 3823; Insurance Code sections 1871 and 1871.4

New claim presumed to be covered by workers' compensation if not denied within 90 days: Labor Code section 5402(b)

Illegal to discriminate against (punish or fire) an injured worker because of the injury: Labor Code section 132a

California Family Rights Act: Government Code section 12945.2

California Fair Employment and Housing Act: Government Code sections 12900 to 12996

Information & Assistance (I&A) officers and I&A services: Labor Code sections 139.6, and 5450 to 5454; Title 8 regulations, sections 9921 to 9929

Workers' compensation judges: Labor Code sections 123.5 and 123.6; Title 8 regulations, section 10348

Chapter 3

Employer must pay for workers' compensation and must have insurance or be self-insured: Labor Code sections 3600 and 3700

Illegal for medical provider to bill injured worker while claim is pending: Labor Code section 3751(b)

Medical care based on treatment guidelines and other scientifically based guidelines: Labor Code sections 4600(b), 4604.5, and 5307.27; Title 8 regulations 9792.8 and 9792.20 to 9792.26

Limits on chiropractic, physical therapy, and occupational therapy visits: Labor Code section 4604.5(c)

Employer must ensure access to emergency medical services: Title 8 regulations, section 3400

Claims administrator must authorize medical treatment within one working day after claim form is filed, up to \$10,000: Labor Code section 5402(c)

Pre-designating your personal physician or a medical group: Labor Code sections 3551(b)(3) and 4600(d); Title 8 Regulations, sections 9780(f), 9780.1, and 9783

Pre-designating your personal physician or a medical group if employer or insurer has a contract with an HCO: Labor Code sections 3551(b)(3) and 4600.3(a); Title 8 regulations, sections 9779.3 to 9779.4

Medical provider networks (MPNs): Labor Code sections 4616 to 4616.7; Title 8 Regulations, sections 9767.1 to 9767.17

Health care organizations (HCOs): Labor Code section 4600.3 to 4600.7; Title 8 regulations, sections 9770 to 9779.8

Right to be treated by your personal physician if employer did not post information about your workers' compensation rights: Labor Code sections 3550(e) and 4616.3(b); Title 8 regulations, sections 9881 and 9881.1

Right to be treated by a physician of your choice if employer or claims administrator fails to provide necessary care or sends you to treatment that is completely inadequate: Labor Code section 4600(a)

Employer's duty to post information about workers' compensation: Labor Code section 3550; Title 8 regulations, sections 9881 and 9881.1

Switching to a different doctor if you are being treated in an MPN: Labor Code section 4616.3; Title 8 regulations, section 9767.6

Switching to a different doctor if you are being treated in an HCO: Labor Code sections 3209.3, and 4600.3(c), (e), and (g); Title 8 regulations, section 9773(b)(6)

Chiropractor may not be treating physician after 24 chiropractic visits: Labor Code section 4600(c)

Duty to inform claims administrator of new treating physician's name and address: Labor Code section 4603.2(a)(1)

Switching to a different doctor if you are not being treated in an MPN or HCO: Labor Code sections 3209.3, 4600(c), and 4601(a); Title 8 Regulations, section 9781

Switching to your personal chiropractor or acupuncturist: Labor Code section 4601(b) and (c); Title 8 regulations, sections 9781(b) and 9783.1

Switching to a different doctor if you are being treated by a predesignated personal physician: Labor Code sections 3209.3, 4600(c), 4600.3(a), (c), (e), and (g), and 4616.3(b); Title 8 regulations, sections 9767.6(d), (e), and (f), 9773(b)(6), 9780.1(d), and 9781.

Treating physician's reports: Title 8 regulations, sections 9785 and 9785.4

Claims administrator must provide copies of medical reports upon request: Title 8 Regulations, section 9810(e)

Physician must provide copies of medical reports upon request: California Health and Safety Code sections 123100 to 123149.5

Chapter 4

Challenging diagnosis or treatment decisions of a treating physician in an MPN: Labor Code sections 4616.3(c), 4616.4, and 4616.6; Title 8 regulations, sections 9767.7, and 9768.1 to 9768.17

Challenging diagnosis or treatment decisions of a treating physician in an HCO: Labor Code sections 4600.3(e) and 4600.5(d)(6); Title 8 regulations, sections 9773(b)(7) and 9775

Challenging diagnosis or treatment decisions of a treating physician not in an MPN or HCO: Labor Code sections 4062 to 4068

Qualified medical evaluators (QMEs): Labor Code section 139.2; Title 8 regulations, sections 10 to 119

Utilization review (UR): Labor Code section 4610; Title 8 regulations, sections 9785, 9785.5, 9792.6 to 9792.10, and 9792.12

Challenging a decision to deny treatment: Labor Code sections 4062(b) and (c), 4610.5, and 4610.6; Title 8 regulations, sections 9792.10 to 9792.10.9 and 9792.12

Penalties for unreasonable delay or denial: Labor Code sections 4610.1, 5814, and 5814.5

Complaints and Audit Unit investigations for failure to meet UR deadlines: Labor Code section 4610(i)

Complaints and Audit Unit investigations of unreasonable delays and denials: Labor Code section 5814.6

Injured worker or claims administrator challenging other types of opinions in a medical report: Labor Code sections 4060 to 4062.5; Title 8 regulations, section 9812(g)

Chapter 5

Eligibility for temporary disability (TD) benefits: Labor Code section 4652

TD benefit amounts: Labor Code sections 4453, 4653 to 4657, and 4661.5

Job-protected leave under the California Family Rights Act (CFRA): Government Code section 12945.2

Notices about TD payments: Labor Code section 138.4(c); Title 8 regulations, section 9812(a), (b), (c), and (d)

When TD payments begin: Labor Code section 4650(a)

TD benefits paid every two weeks: Labor Code section 4650(c)

Delay letter regarding TD benefits: Title 8 regulations, section 9812(a)(2)

New claim presumed to be covered by workers' compensation if not denied within 90 days: Labor Code section 5402(b)

Penalties for delay in TD payments: Labor Code sections 4650(d) and 5814

When TD payments end: Labor Code section 4656

Notice about ending of TD benefits: Title 8 regulations, section 9812(d)

Chapter 6

Medical reports and work restrictions while recovering: Labor Code section 4061.5; Title 8 regulations, sections 9785 and 9785.2

Illegal to discriminate against (punish or fire) an injured worker because of the injury: Labor Code section 132a

"Description of Employee's Job Duties" form: Title 8 regulations, section 10133.33

Offers of work and supplemental job displacement benefits: Labor Code sections 4658.5, 4658.6, and 4658.7; Title 8 regulations, sections 9813.1, 10116.9, and 10133.31 to 10133.60

Illegal to discriminate against (punish or fire) an injured worker because of the injury: Labor Code section 132a

California Fair Employment and Housing Act (FEHA): Government Code sections 12900 to 12996

Chapter 7

Definitions of "permanent disability": Labor Code sections 4660, 4660.1, and 4662; Title 8 regulations, section 10152

Permanent and stationary (P&S) report: Labor Code section 4663; Title 8 regulations, sections 9785(g), 9785.3, 9785.4, and 10152

Ratings: Labor Code sections 4452.5, 4660, 4660.1, 4662, 4663, and 4664; Title 8 regulations, sections 10150 to 10167

Rating schedules: Labor Code sections 4658(d)(4) and 4660; Title 8 regulations, sections 9725 to 9727, 9805, and 9805.1

Ratings by a disability rater: Title 8 regulations, sections 10150 to 10167

Reconsideration of a rating by a disability rater: Title 8 regulations, section 10164

Permanent disability (PD) benefit amounts: Labor Code sections 4658, 4658.1, 4659, 4660, 4660.1, 4661, 4662, 4663, and 4664

Decrease or increase in PD benefits by 15% depending on whether or not employer offers work: Labor Code section 4658(d)(2) and (3); Title 8 regulations, section 10117

“Notice of Offer of Regular Work” (form DWC-AD 10118): Title 8 regulations, section 10118

“Notice of Offer of Modified or Alternative Work” (form DWC-AD 10133.53): Title 8 regulations, section 10133.53

When PD payments begin: Labor Code section 4650(b)

PD benefits paid every two weeks: Labor Code section 4650(c)

When PD benefits are decreased or increased by 15%: Title 8 regulations, section 10117

Notices about PD benefits: Labor Code sections 138.4(c) and 4061; Title 8 regulations, section 9812(g)

Penalties for delay in PD benefits: Labor Code sections 4650(d) and 5814

Stipulations with Request for Award: Labor Code section 5702; Title 8 regulations, sections 10496, 10497, and 10875 to 10882

Compromise and Release: Labor Code sections 5000 to 5106; Title 8 regulations, sections 10870 to 10882

Changes in benefits and reopening a case: Labor Code section 5410

Findings and Award: Labor Code sections 5800 to 5816

Chapter 8

Offers of work and supplemental job displacement benefits: Labor Code sections 4658.5, 4658.6, and 4658.7; Title 8 regulations, sections 9813.1, 10116.9, and 10133.31 to 10133.60

Dollar amounts of vouchers: Labor Code sections 4658.5(b) and 4658.7(d)

Chapter 9

Return to Work Supplemental Program: Labor Code section 139.48, 4658.7; Title 8 regulations, sections 17300 to 17310.

Appendix B. Glossary



This glossary briefly explains many of the terms that are commonly used in workers' compensation. These are not the full legal definitions.

ACOEM. American College of Occupational and Environmental Medicine. Portions of guidelines published by ACOEM, called “Occupational Medicine Practice Guidelines,” are incorporated in the Medical Treatment Utilization Schedule adopted by the Division of Workers’ Compensation.

AMA. American Medical Association. For workers whose permanent disability must be rated using the 2005 rating schedule, the treating physician is required to rate the worker’s impairment using guidelines published by AMA called, “Guides to the Evaluation of Permanent Impairment.”

AOE/COE. “Arising out of and in the course of employment,” or caused by a worker’s job and occurring while working. An injury or illness must be AOE/COE to be covered by workers’ compensation.

Accepted claim. A workers’ compensation claim in which the claims administrator agrees that the worker’s injury or illness is covered by workers’ compensation. Even if a claim is accepted, however, there may be delays or other problems. Also called “admitted claim.”

Agreed medical evaluator (AME). A doctor who is selected by agreement between the injured worker’s attorney and the claims administrator to conduct a medical examination and prepare a medical-legal report to help resolve a dispute.

Alternative work. If a treating physician reports that an injured worker will never recover completely or be able to return to the same job or working conditions that he or she had before injury, the employer may offer alternative work instead of a supplemental job displacement benefit. This is work that is different from the worker’s old job. It must meet the worker’s work restrictions, pay at least 85 percent of the wages and benefits that were paid at the time of injury, last at least 12 months, and be within a reasonable commuting distance of where the worker lived at the time of injury.

Americans with Disabilities Act (ADA). A federal law that prohibits discrimination against disabled persons. Employment provisions of the ADA are administered by the US Equal Employment Opportunity Commission (EEOC).

Appeals Board. A group of seven commissioners who review and reconsider decisions of workers’ compensation administrative law judges.

Applicants’ attorney. A lawyer who represents injured workers in their workers’ compensation cases. “Applicant” refers to the injured worker.

Apportionment. An estimate of how much an injured worker’s permanent disability is caused by the worker’s job, as compared to other factors.

Cal/OSHA. The Division of Occupational Safety and Health, which is a state agency that inspects workplaces and administers laws to protect the health and safety of workers in California.

California Family Rights Act (CFRA). A state law, administered by the California Department of Fair Employment and Housing, that requires most employers of 50 or more employees to grant job-protected leave to workers with serious health problems or who need to care for a child or other family member.

California Labor Code section 132a. A state law that prohibits discrimination against injured workers for having a work injury or filing a workers' compensation claim. The law also prohibits discrimination against co-workers who testify in the injured worker's case.

Carve-out. An alternative to the dispute resolution procedures in the California workers' compensation system. Carve-outs can be created only through collective bargaining agreements between labor unions and employers.

Challenge. Disagree with, object to, or place in dispute.

Claim Form (DWC 1). A form that a worker uses to request workers' compensation benefits in writing.

Claims adjuster. See "claims administrator."

Claims administrator. A person who handles workers' compensation claims for employers. Most claims administrators work for insurance companies or other organizations that handle claims for employers. Some claims administrators work directly for large employers that handle their own claims. Also called "claims examiner" or "claims adjuster."

Claims examiner. See "claims administrator."

Commission on Health and Safety and Workers' Compensation (CHSWC). A state-appointed body, consisting of four labor and four management representatives, that sponsors and conducts ongoing studies and makes recommendations to improve the California workers' compensation system and the state's activities to prevent job injuries.

Compromise and release (C&R). A type of settlement where the worker receives a lump sum payment and may become responsible for paying for future medical care for the injury.

Cumulative injury. An injury that was caused by repeated events or repeated exposures at work. Examples: hurting one's wrist from doing the same motion over and over, losing hearing ability because of constant loud noise.

Date of injury. If the injury was caused by one event (a specific injury), this is the date of the event. If the injury was caused by repeated exposures (a cumulative injury), this is the date that the worker knew or should have known that the injury was caused by work.

Death benefits. Payments to the spouse, children, or other dependents of a worker who dies from a job injury or illness.

Delay letter. A letter sent by the claims administrator to the injured worker that explains why payments are delayed, what information is needed before payments will be sent, and when a decision will be made about the payments.

Denied claim. A workers' compensation claim in which the claims administrator believes that the worker's injury or illness is not covered by workers' compensation, and has notified the worker of this decision.

Description of Employee’s Job Duties (DWC AD form 10133.33). A form that is filled out jointly by the injured worker and the employer or claims administrator to help the treating physician determine whether the worker is able to return to his or her usual job and working conditions. The information on the form also helps the physician specify appropriate work restrictions.

Disability rater. An employee of the Division of Workers’ Compensation who rates an injured worker’s permanent disability after reviewing a medical report or a medical-legal report that describes the worker’s condition. Also called “disability evaluator.”

Disability rating. See “permanent disability rating.”

Dispute. A disagreement about a worker’s right to receive payments, services, or other benefits.

Division of Workers’ Compensation (DWC). A state agency that administers workers’ compensation laws, adjudicates disputes, and provides information and assistance to injured workers and others about the California workers’ compensation system.

Fair Employment and Housing Act (FEHA). A state law, administered by the California Department of Fair Employment and Housing, that prohibits discrimination against disabled persons. Its provisions are more extensive in some areas than the federal Americans with Disabilities Act (ADA).

Family and Medical Leave Act (FMLA). A federal law, administered by the US Department of Labor, that requires most employers of 50 or more employees to grant job-protected leave to workers with serious health problems or who need to care for a child or other family member.

Filing. Sending or delivering a document to an employer or a governmental agency as part of a legal process. The date of filing is the date the document is received.

Findings and Award. A written decision by a workers’ compensation administrative law judge about an injured worker’s case, including payments and future medical care that must be provided to the worker.

Health care organization (HCO). An organization certified by the Division of Workers’ Compensation that contracts with an employer or insurer to provide managed medical care in the California workers’ compensation system.

Hearing. A legal proceeding or event where a workers’ compensation administrative law judge holds a meeting to discuss issues or receives information from different persons in order to make a decision about a dispute or a proposed settlement.

Independent Medical Review (IMR). This term refers to two different processes:

- Independent review of a decision, communicated by a claims administrator, to deny or modify treatment recommended by a treating physician. An injured worker may request this type of IMR if the worker’s date of injury is on or after January 1, 2013, or the claims administrator communicated the decision to deny treatment on or after July 1, 2013.
- Independent review of a treatment decision made by a treating physician in a medical provider network (MPN). An injured worker may request this type of IMR if the worker is being treated in an MPN and has obtained opinions from two other physicians in the MPN.

Impairment rating. A percentage that estimates how much a worker has lost the normal use of injured parts of the body. Impairment ratings are determined based on guidelines published by the American Medical Association (AMA). Different from “permanent disability rating.”

Information & Assistance (I&A) officer. An employee of the Division of Workers’ Compensation who answers questions, assists injured workers, provides written materials, conducts informational workshops, and holds meetings to informally resolve problems with claims. Most of their services are designed to help workers who do not have an attorney.

Injury and Illness Prevention Program (IIPP). A health and safety program that employers are required to develop and implement. This requirement is enforced by Cal/OSHA.

Judge. See “workers’ compensation administrative law judge.”

Maximal medical improvement (MMI). See “permanent and stationary (P&S).”

Medical care. See “medical treatment.”

Medical-legal report. A report written by a doctor to help clarify one or more disputed medical issues concerning a worker’s injury or medical condition.

Medical provider network (MPN). A set of physicians and other health care providers selected by an employer or insurer to treat injured workers in the California workers’ compensation system. MPNs must be approved by the Division of Workers’ Compensation.

Medical treatment. A workers’ compensation benefit, offered to the injured worker, that is “reasonably required to cure or relieve from the effects of the injury.” Also called “medical care.”

Medical treatment utilization schedule (MTUS). A set of guidelines and an analytical framework adopted by the Division of Workers’ Compensation, based on scientific evidence and nationally recognized standards of care, that address the appropriate extent and scope of treatment commonly performed in workers’ compensation cases.

Medical Unit. A unit within the Division of Workers’ Compensation that oversees utilization review (UR) plans, independent medical review (IMR) of decisions to deny treatment recommended by a treating physician, medical provider networks (MPNs), independent medical review (IMR) of treatment decisions made by MPN physicians, health care organizations (HCOs), and qualified medical evaluators (QMEs).

Modified work. If a treating physician reports that an injured worker will never recover completely or be able to return to the same job or working conditions that he or she had before injury, the employer may offer a modified job instead of a supplemental job displacement benefit. This is the worker’s old job with changes that meet the doctor’s work restrictions; it must pay at least 85 percent of the wages and benefits that were paid at the time of injury, last at least 12 months, and be within a reasonable commuting distance of where the worker lived at the time of injury.

Notice of Offer of Modified or Alternative Work (DWC-AD 10133.53). For dates of injury 2004 through 2012: A form that an employer or claims administrator sends to an injured worker with a permanent disability. If the employer makes this offer within 30 days after the worker’s final temporary disability (TD) payment, the claims administrator is not required to provide a supplemental job displacement

benefit (SJDB). If the worker was injured sometime in 2005 through 2012, the employer has 50 or more employees, and this offer is made within 60 days after the worker's condition becomes permanent and stationary (P&S), permanent disability (PD) payments are reduced by 15 percent; otherwise, PD payments are increased by 15 percent.

Notice of Offer of Regular, Modified, or Alternative Work (DWC-AD 10133.35). For dates of injury in 2013 or later: A form that an employer or claims administrator sends to an injured worker with a permanent disability. If the employer makes this offer within 60 days after the claims administrator learns the worker has a permanent partial disability (PPD) that has become permanent and stationary (P&S), the claims administrator is not required to provide a supplemental job displacement benefit (SJDB).

Notice of Offer of Regular Work (DWC-AD 10118). For dates of injury 2005 through 2012: A form that an employer or claims administrator sends to an injured worker with a permanent disability. If the employer has 50 or more employees and this offer is made within 60 days after the worker's condition becomes permanent and stationary (P&S), permanent disability (PD) payments are reduced by 15 percent; otherwise, PD payments are increased by 15 percent.

Objective factors. Measurements, direct observations, and test results that a treating physician, a QME, or an AME describes as contributing to an injured worker's permanent disability.

P&S report. A medical report written by a treating physician that describes the injured worker's medical condition when it has stabilized. See also "permanent and stationary."

Penalty. A fine charged to an employer or claims administrator and paid to the injured worker. It can refer to an automatic 10 percent penalty for a delay in one payment, or a 25 percent penalty, up to \$10,000, for an unreasonable delay.

Permanent and stationary (P&S). The point at which a doctor reports that the injured worker's condition has stabilized, or is not expected to get any better or any worse. For workers whose permanent disability must be rated using the "2005 Schedule for Rating Disabilities," this is referred to as the point in time when the worker has reached maximal medical improvement (MMI). See also "P&S report."

Permanent disability (PD) benefits. Payments to a worker whose job injury permanently limits the kinds of work the worker can do. Permanent partial disability (PPD) benefits are payments to a worker who is partially limited in the kinds of work he or she can do. Permanent total disability (PTD) benefits are payments to a worker who is considered permanently and completely unable to work.

Permanent disability (PD) rating. A percentage that estimates how much a job injury permanently limits the kinds of work the worker can do. It is based on the worker's medical condition, date of injury, age when injured, occupation when injured, and apportionment (how much the disability is caused by the job compared to other factors).

Personal physician. A doctor licensed in California with an MD degree (medical doctor) or a DO degree (osteopath), who has treated the injured worker in the past and has his or her medical records. The doctor must be a general practitioner, internist, pediatrician, obstetrician-gynecologist, or family practitioner who is the worker's primary care physician. "Personal physician" can refer to a medical group that provides comprehensive medical services mostly for medical conditions unrelated to work.

Physician. A medical doctor, an osteopath, a psychologist, an acupuncturist, an optometrist, a dentist, a podiatrist, or a chiropractor licensed in California. See the definition of "personal physician" above.

Predesignation. A worker telling his or her employer in writing, before getting hurt on the job, the name and address of the worker's personal physician in case of job injury. This physician must be the worker's primary care physician and must agree to be predesignated. A worker may also predesignate a medical group. If a worker predesignates, he or she will be allowed to be treated by the personal physician right after injury instead of a physician selected by the employer or the claims administrator. Workers can predesignate only if, on the date of injury, the worker has health care coverage for medical conditions that are unrelated to work. See also "personal physician."

Primary treating physician (PTP). The doctor who is responsible for managing the overall care of the injured worker and who writes medical reports that may affect the worker's benefits.

Qualified medical evaluator (QME). A doctor who is selected by either an injured worker, an injured worker's attorney, or a claims administrator, from a list provided by the Division of Workers' Compensation, to conduct a medical examination and prepare a medical-legal report to help resolve a dispute. QMEs are certified by the Division of Workers' Compensation.

Rating. See "permanent disability rating."

Reconsideration. A legal process for appealing a decision made by a workers' compensation administrative law judge.

Reconsideration of a summary rating. A process for determining whether mistakes were made in determining the permanent disability rating of an injured worker who does not have an attorney.

Regular work. An injured worker's old job, paying the same wages and benefits as paid at the time of injury and located within a reasonable commuting distance of where the worker lived at the time of injury.

Restrictions. See "work restrictions."

Return-to-work supplement. A supplemental benefit for injured workers, injured in 2013 or later, who have received a supplemental job displacement benefit (SJDB) voucher and who experience a disproportionate loss of earnings.

Schedule for Rating Permanent Disabilities. A state publication containing detailed information that is used to rate permanent disabilities. There are three schedules. See Chapter 7.

Settlement. An agreement between an injured worker and the claims administrator about the workers' compensation payments and future medical care that will be provided to the worker. Settlements must be reviewed by a workers' compensation administrative law judge to determine whether they are adequate to compensate the injured worker for the injury.

Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. Financial assistance for disabled persons. These benefits are administered by the US Social Security Administration. They may be reduced by workers' compensation payments that the injured worker receives.

Specific injury. An injury that was caused by one event at work. Examples: hurting one's back in a fall, getting burned by a chemical that splashes on the skin, getting hurt in a car accident while making deliveries.

State Disability Insurance (SDI). Short-term financial assistance for disabled workers in California. Workers with job injuries may apply for SDI benefits when workers' compensation payments are delayed or denied. These benefits are administered by the Employment Development Department (EDD).

State average weekly wage (SAWW). The average weekly wage paid to employees in California who were covered by unemployment insurance, as reported in the previous year by the US Department of Labor.

Stipulations with request for award (Stips). A type of settlement where the claims administrator usually agrees to continue paying for medical care for the injury.

Subjective factors. An injured worker's pain and other symptoms, not directly measured or observed, that a doctor describes as contributing to the worker's permanent disability.

Supplemental job displacement benefit (SJDB). A workers' compensation benefit for injured workers, injured in 2004 or later, who have a permanent partial disability (PPD) that prevents them from doing their old job and whose employers do not offer other work. It is in the form of a voucher that promises to help pay for educational retraining, skill enhancement, or both. Also called "voucher."

Supplemental Job Displacement Non-Transferable Voucher Form (DWC-AD 10133.32 or DWC-AD 10133.57). A form that a claims administrator uses to provide a supplemental job displacement benefit, or voucher, to an injured worker with a permanent disability. Form DWC-AD 10133.32 is used for dates of injury in 2013 or later. Form DWC-AD 10133.57 is used for dates of injury 2004 through 2012.

Temporary disability (TD) benefits. Payments to an injured worker who loses wages because the injury prevents the worker from doing his or her usual job while recovering. Temporary partial disability (TPD) benefits are payments to a worker who can do some work while recovering, but who earns less than before the injury. Temporary total disability (TTD) benefits are payments to a worker who cannot work at all while recovering.

Treating doctor or treating physician. An injured worker's primary treating physician (PTP) or other physician who treats the injured worker and whose findings are incorporated into the PTP's medical reports.

Uninsured Employers Benefits Trust Fund (UEBTF). A possible source of workers' compensation benefits for an injured worker whose employer is illegally uninsured in California. These benefits are administered by the state Division of Workers' Compensation.

Utilization review (UR). The process used by claims administrators to decide whether to authorize and pay for treatment recommended by the treating physician or another doctor.

Voucher. See "supplemental job displacement benefit."

Work restrictions. A doctor's description of clear and specific limits on an injured worker's job tasks, usually designed to protect the worker from further injury.

Workers' Compensation Appeals Board (WCAB). The Appeals Board and workers' compensation administrative law judges.



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