Workers Compensation Benefits Overview - California

Major Developments: Last major legislation in 2004 (SB899), affected indemnity rates, disability rating, medical treatment, medical-legal disputes, penalties, and apportionment. 2007 legislation affects caps on TD and post-surgical treatments.

INDEMNITY ISSUES

Temporary Total Benefits

Calculated as 2/3 AWW, subject to the statutory minimum and maximums at time of injury. Current minimum is *$143.70* and current maximum is *$958.01*. A 3-day waiting period applies, reimbursed after the 14th day of disability. (No waiting period applies if immediately hospitalized). Payments at 2 years or more from the date of injury are subject to current statutory limits (known as the "2-year rule").

Temporary Partial Benefits

Also known as Wage Loss. Calculated as AWW (subject to statutory min/max) minus current earnings, multiplied by 2/3.

Permanent Partial Benefits

Awarded by the treating or med-legal physician. For injuries on or after 2005 and certain pre-2005 claims, PPD is calculated according to the AMA Guides for Rating Disability, 5th ed. The percentage awarded is adjusted for age, occupation, and diminished future earning capacity, with each percentage corresponding to a set number or weeks of disability. PPD is also calculated as 2/3 AWW, but with different min/max, dependent upon the date of injury and amount of disability. Current minimum: $130.00, current maximum: $270.00. PPD of 70% or more require payment of Life Pension (LP) benefits following payout of the PPD award. LP rates are 2/3 AWW but are subject to a formula and have much lower min/max, dependent upon the date of injury. COLA adjustments apply to LP cases with dates of injury on or after 1/1/03, effective 1/1/04.

Once there is a reasonable expectation of PD, PD benefits must be advanced at the appropriate rate within 14 days of knowledge. Exceptions would be when the injured worker declines such advances or is receiving TD benefits. For injuries on or after 1/1/05, remaining weekly PD advances can be reduced 15% if a valid offer of regular, modified, or alternative work is made within 60 days of P&S (now known as MMI). This reduction can be taken at the time the offer is made. If no valid offer is timely made, the remaining weekly PD advances must be increased 15% as of the 61st day from P&S (MMI). Employers with less than 50 employees are exempt from the 15% adjustments. Lump sum PD advances are allowed in hardship cases, of which a 3% discount can be commuted off the far end of the award.

Permanent Total Benefits

Calculated the same as TTD, but not subject to adjustments two or more years from date of injury ("2-year rule") Beginning 1/1/04, PTD cases with dates of injury on or after 1/1/03 are subject to COLA adjustments.

Workers Compensation Benefits Overview - California

(Indemnity Issues Continued)

Fatality Benefits

Death benefits are calculated at 2/3 AWW, with a minimum of $224.00 and a maximum of $958.01, with total payout of $125,000 to $320,000.00, depending on the number and type of dependents. In cases, with no dependents, the benefit is paid to the state. Minor dependent children are entitled to benefits until they reach age 18, and physically or mentally incapacitated dependents are entitled to benefits for life. Both may exceed the maximums previously mentioned. Both may exceed the maximums previously mentioned. Payments at 2 years or more from the date of injury are subject to current statutory limits (known as the "2-year rule"). Burial Expenses: Up to $5,000.00. Application for death benefits must be filed within one year of date of death or 240 weeks from date of injury.

Vocational Rehabilitation

Applies to dates of injury prior to 1/1/04. Entitlement is contingent upon a finding by the treating or med-legal physician and a request from the injured worker. VR indemnity benefits (known as Vocational Rehabilitation Maintenance Allowance, or VRMA), are calculated as 2/3 AWW, but for injuries between 1/1/90 and 1/1/04, the maximum is $246.00 per week. These can be supplemented with PD advances up to the TD rate. *Effective 1/1/09, the DWC Vocational Rehabilitation Unit ceased to exist.*

For injuries on or after 1/1/04, workers are entitled to Supplemental Job Displacement Benefits (SJDB) if the employee is awarded PD and 1) the employee does not return to work within 60 days of termination of TD, or 2) the employer fails to offer modified or alternative work within 30 days of termination of TD.

Settlement Allowed

Parties can settle all indemnity issues without trial, but every settlement requires approval by a Workers' Compensation Judge or Board. These usually consist of a Stipulations With Request for Award (Stip), or a Compromise and Release (C&R). A Stip may be reopened within 5 years from the date of injury for new and further disability, but a C&R, or lump sum settlement, cannot be reopened for new and further disability.
If no settlement is reached, the parties can proceed to the WCAB for a Findings and Order. For any compensation due under a WCAB award, interest is payable from the first day of the award at 10% annum. This also applies to Stips and C&Rs unless the settlement documents specify interest included.

Cap on Benefits, exceptions

TTD: For injuries on or after 4/19/04, benefits are held to 104 weeks within 2 years from the date of the first payment. Exceptions apply to certain injuries, of which benefits are held to 240 weeks within 5 years from the date of injury. For injuries on or after 1/1/08, benefits are held to 104 weeks within 5 years from the date of injury.

TPD: In addition to the time limitations for TTD noted above, for injuries after 1/1/79 but before 4/19/04, TP is held to 240 weeks within 5 years from the date of injury.

VRMA: Held to 52 weeks, but can exceed if VR plan found inappropriate or proper VR notices not timely sent. Total VR costs held to $16,000.00 for dates of injury on or after 1/1/90. Same exceptions to VRMA can exceed the overall cap.

SJDB: Depending upon the amount of PD awarded, SJD benefits have a maximum of $10,000.00.

MEDICAL ISSUES

Initial Choice of Provider

The employer has initial medical control for the first 30 days, unless there is a Medical Provider Network (MPN) in place. Employers who utilize an MPN have, barring certain exceptions, medical control for the life of the claim. Workers who pre-designate their treating doctor prior to injury can treat with that physician at the onset of injury despite an MPN in place.

Change of Provider

Within the first 30 days, the injured worker can request a change of provider. After the first 30 days, the worker can select a provider of his or her choosing within a reasonable geographic area. If an MPN is in place, the worker can change providers at any time, but must select a physician within the MPN.

Medical Fee Schedule

CA has an official medical fee schedule covering inpatient and outpatient hospital services, pharmaceuticals, durable medical equipment, prosthetics, pathology, laboratory and ambulance services. Out-patient services outside of a hospital setting cannot exceed 120 % of the fee for the same procedure under the Medicare ambulatory payment classification facility (APC) fee schedule. Pharmacy services and drugs not covered by Medicare's APC fee schedule are limited to 100% of the relevant Medi-Cal Fee schedule.

Managed Care

Yes, Medical Provider Networks must be approved by the state and are subject to regulatory review.

Utilization Review

All medical treatment can be subject to utilization review on retrospective, concurrent, and prospective bases. UR plans must be approved by the state and are subject to regulatory review. UR responses must be made, in most cases, within 5 working days of a written request for current or prospective reviews, 30 days for retrospective reviews, and 72 hours for concurrent or prospective expedited reviews. Objections to UR denials must be filed within 20 days by requesting a Qualified Medical Evaluation (QME) if unrepresented, or Agreed Medical Evaluation (AME) if represented.

Treatment Guidelines

Yes. ACOEM Medical Guidelines holds a statutory presumption of correctness, but all treatment must be in accordance to evidence- based, nationally recognized guidelines.

Workers Compensation Benefits Overview - California

(Medical Issues Continued)

Medical Mileage Reimbursement Rate

The current medical mileage reimbursement rate, effective 1/1/09, is 55 cents per mile.

Network Information

The Network Contact for California is *Theresa Taylor (909-612- 3055)*. TTAYLOR1@travelers.com.

Ability to Terminate Medical Treatment

The employer can terminate medical treatment upon a finding by the treating or medical-legal physician that no further treatment is reasonably necessary. Awards for ongoing or future medical treatment require a finding by the Workers' Compensation Appeals Judge or Board before liability for medical treatment can be terminated.

Settlement Allowed

Parties can settle all medical issues without trial, but every settlement requires approval by a Workers' Compensation Judge or Board. These usually consist of a Stipulations With Request for Award (Stip), or a Compromise and Release (C&R). A Stip may be reopened within 5 years from the date of injury for new and further disability, but a C&R, or lump sum settlement, cannot be reopened for new and further disability.

Cap on Benefits, exceptions

For injuries on or after 1/1/04, chiropractic, occupational, and physical therapy visits are held to 24 each unless the administrator agrees to exceed this cap.

Effective 1/1/08, these caps do not apply for post-surgical cases, providing the treatment is in accordance with the post-surgical treatment utilization guidelines established by the Administrative Director. Beyond this, medical benefits can be awarded for life but must be reasonably necessary and in accordance to ACOEM or other evidence-based, nationally recognized guidelines. Where the claim is delayed for the purposes of compensability determination, medical treatment must still be provided until either the claim is denied or a total of $10,000.00 in medical expenditures is reached, whichever occurs first.

OTHER ISSUES

Staff Council

Law Offices of Susan T. Marks 215 Lennon Lane, #200 Walnut Creek, CA 94598 (925) 945-4491

Law Offices of Joe Ellie 11070 White Rock Rd., Suite 200 Rancho Cordova CA 95670 (916) 638-6610

Law Offices of Brett Barnard & Associates Diamond Bar, CA (909) 612-3870

Hearings Require Attorney or Claim Handler Participation

Claim handlers can handle any and all matters before the WCAB, including trials and appeals.

Occupational Diseases

Occupational diseases and repetitive trauma can both be compensable in the CA workers' compensation system. The date of injury for occupational diseases is the date the claimant first suffered disability and knew, or should have reasonably known, that the condition was industrial.

Second Injury Fund Availability

The Subsequent Injury Fund is available to injured workers who have a subsequent injury to an opposite member (eye, ear, arm, hand, foot, etc.) where the combined injuries total 70% or more, where each injury is at least 5% before age and occupational adjustment of the total, or the subsequent injury, before age and occupational adjustment is at least 35% or more of the total.

Other Offset Opportunities

Apportionment is to causation of disability and applies only to permanent disability. It can be pathologic, systemic, or idiopathic, but requires substantial evidence. In most cases, a conclusive presumption of apportionment applies to any prior disability award, but defendants have the burden to show duplication. Apportionment must be approved by a judge. Contribution can be obtained from a co-defendant, such as another employer or insurer, and against all benefits provided. Parties have one year to file for contribution against a co-defendant. Subrogation can be pursued against third- party tortfeasors. The statute of limitations for subrogating is two years.

EDI

Release version 1 in place. Administrators must file the FROI, SROI, Annual, and Final reports electronically with the state. Anticipate medical reporting later this year.

Workers Compensation Benefits Overview - California

(Other Issues Continued)

Penalties

Any unpaid or late indemnity benefit is subject to self-imposed 10% penalty if the injured worker has previously returned a completed DWC-1 Employee Claim form. Any unreasonably delayed or refused payment of compensation can also warrant a court-assigned penalty, up to 25% of the amount unreasonably delayed or refused *(or $10,000.00, whichever is less)*. More than one such penalty in a five-year period can prompt a state audit for a potential general business practice penalty.

Undisputed medical treatment charges not paid within 45 working days of receipt of the bill are subject to a self-imposed 15% penalty, plus 10% interest. Undisputed medical-legal expenses not paid within 60 calendar days of receipt of the charges are subject to a self- imposed 10% penalty and 7% interest is due.

Notices

Mandatory benefit notices are required anytime an indemnity benefit is started, delayed, stopped, or denied. The notice must be sent at the time the benefit is paid, delayed, stopped, or denied, and must include an explanation, along with the amount in question and how it was calculated. PD notices must notify the injured worker of his/her right to a Qualified or Agreed Medical Evaluator, should a dispute arise. A Denial notice must be sent within 90 days of receipt of a completed DWC-1 Employee Claim form. Otherwise, the claim is presumed compensable.

In-State Adjusting Required? No.

License or Certification Required

Case Managers are required to be designated as Claim Adjusters or Experienced Claims Adjusters. Trainees who are not designated as Claims Adjusters may become designated after completing 160 hours of training within a 12-month period or passing the state Self- Insured Plans Certification of Competency Exam. During the 12- month period, trainees may manage claims under the supervision of a designated Instructor or Experienced Claims Adjuster. Case Managers administering self-insured claims must pass the state Self- Insured Plans Certification of Competency Exam or work under the direct supervision of one who has passed the exam. Medical-Only Case Managers and Bill Reviewers must also be designated as such, and have similar, though less stringent, requirements for training and designation. Also, all must complete minimal Continuing Education Units to maintain their designations.

Administrators who administer self-insured claims must hold a valid Certificate of Consent to Administer from Self-Insured Plans.

Comments

Since passage of SB899, the courts have been continuously interpreting it, and the state has been revising or creating regulations surrounding it.

Recent passed and proposed regulations affect post-surgical medical treatment and *chronic pain, state audits,* Qualified Medical Evaluators*, employer reporting of claims, and the California Permanent Disability Rating Schedule.*

Source: Travelers Indemnity Company
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