TRAVELERS

# Workers Compensation Claim
# State Environmental Guide - California

**CALIFORNIA –** http://www.dir.ca.gov/dwc/dwc_home_page.htm

**Indemnity issues**

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| Temporary Total Benefits (TT) | Worker's average weekly wage (AWW) computed as 2/3 of the worker's prior 52-week earnings history, subject to the statutory minimum and maximum at time of injury. Current minimum is $175.88 and current maximum is $1,172.57. A 3-day waiting period applies, reimbursed after the 14th day of disability. (No waiting period applies if immediately hospitalized).<br>Payments made 2 years or more from the date of injury are subject to statutory limits in effect on the date of the payment (known as the "2-year rule"). Subsequent payments are subject to adjustment every January 1st, if applicable.<br>*For DOI 1/1/18, statutory max AWW = $1,822.91 (max TD = $1,215.27) |
| Temporary Partial Benefits (TP) | Also known as Wage Loss. Calculated as AWW (subject to statutory min/max for temporary total benefits) minus current earnings, multiplied by 2/3. |
| Permanent Partial Benefits (PD) | Awarded by the treating or medical-legal physician. For injuries on or after 2005 and certain pre-2005 claims, PD is calculated according to the AMA Guides to the Evaluation of Permanent Impairments, 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. However, court decisions allowing deviations within the AMA Guides and deviation from the scheduled diminished future earning capacity based on post-injury earnings, have been upheld by the Appellate and Supreme Courts.<br>PD is also calculated as 2/3 AWW, but with different min/max, dependent upon the date of injury and amount of disability. The current minimum weekly PD rate for injuries on or after 1/1/13 is $160.00. The current maximum weekly PD rate for injuries on or after 1/1/13 but before 1/1/14 ranges from $230 to $290, depending upon the level of permanent disability.<br>For injuries on or after 1/1/14, the maximum rate is $290, regardless of the level of permanent disability. PD of 70% or more requires payment of Life Pension (LP) benefits following payout of the PD 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.<br>COLA adjustments apply to LP benefits with dates of injury on or after 1/1/03, effective 1/1/04. The COLA adjustment is applied to the LP benefit every January 1st following the first payment. 2016 COLA modifier 1.02278639 |

**Indemnity issues**

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| Permanent Partial Benefits (PD) | Prior to 1/1/13, when there was a reasonable expectation of permanent disability, PD advances were to be initiated within 14 days of ending TT benefits.<br>After 1/1/13, PD advances are not due within 14 days of TT benefits ending or prior to the approval of an award if: the employer offers position at 85% of wages at date of injury or if employee returns to work with another employer earning at least 100% of wages at date of injury.<br>For injuries on or after 1/1/05, but before 1/1/13, remaining weekly PD advances can be reduced 15% if a valid offer of regular, modified, or alternative work is made within 60 days of the Permanent and Stationary (P&S) date, also known as the date Maximum Medical Improvement (MMI) was achieved. 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).<br>Employers with less than 50 employees are exempt from the 15% increase. The 15% adjustments do not apply to injuries on or after 1/1/13. Lump sum PD advances are allowed in hardship cases, of which a 3% discount can be commuted off the far end of the award. Must be approved by a judge.<br>For injuries on or after 1/1/13, sleep disorder, sexual dysfunction, and, barring certain exceptions, psychiatric disorder "add-ons" to physical injuries, can no longer increase permanent disability, if claimed as a compensable consequence, but there is still liability for medical treatment.<br>For injuries on or after 1/1/13, when converting WPI to PD, the FEC modifier is eliminated and replaced with a 1.4 modifier of the WPI. |
| Permanent Total Benefits (PT) | Calculated the same as TD, but not subject to adjustments two or more years from date of injury ("2-year rule") Beginning 1/1/04, PTT cases with dates of injury on or after 1/1/03 are subject to COLA adjustments. |
| Fatality Benefits | Death benefits are calculated at 2/3 AWW and are paid in the same manner and amounts and as TT benefits, with a minimum of $224.00 and a maximum of 01/01/2016 $1,128.43, with total payout of $250,000 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.<br>Payments at 2 years or more from the date of injury are subject to current statutory limits in effect on the date of payment (known as the "2-year rule").<br>Burial Expenses: Up to $10,000. Application for death benefits must be filed within one year of date of death or 240 weeks from date of injury. |
| Vocational Rehabilitation | No longer applicable. Sunset 12/31/2007. |

**Indemnity issues**

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| Supplemental Job Displacement Benefit | 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 TT, or, 2) in cases where the employee does not return to work within 60 days, the employer fails to offer modified or alternative work within 30 days of termination of TT**.**<br>For dates of injury 1/1/04 – 12/31/12, the voucher is due to the injured worker within 25 days of a stipulated award being approved.<br>For dates of injury on or after 1/1/13, if, within 60 days of receiving the P&S/MMI report, the employer is not able to provide the injured employee modified or alternative employment in line with the work restrictions provided in the MMI/P&S report, the employee is due the voucher no more than 20 days after the 60th day of receiving the report. |
| Return to Work Program | Effective April 13, 2015, SB 863 establishes in the Department of Industrial Relations a return to work program to be funded by non-general revenues of one hundred twenty million dollars ($120,000,000.00) that the bill would annually appropriate from the Workers Compensation Administration Revolving Fund.<br>For dates of injury on or after 1/1/13 injured workers who were provided with an SJDB voucher are eligible for a one-time $5,000 return-to-work supplement payable by the state. The application for the one-time supplement must be submitted within one year of service of the SJDB voucher or one year from 4/13/15, whichever is later. The SJDV also needs to include a proof of service to be eligible for the $5,000 supplement. |
| Settlement Allowed | Parties can settle all indemnity issues, except for the SJDB for dates of injury on or after 1/1/13, without trial, but every settlement requires approval by a Workers' Compensation Judge or the Appeals Board. Settlements usually consist of a Stipulations With Request for Award (Stip), or a Compromise and Release (C&R). There is some legal authority for settlement of the voucher in denied cases.<br>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.<br>If no settlement is reached, the parties can proceed to the WCAB for a Findings and Award/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 | TD: 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 with the same exceptions that are held to 240 weeks.<br>TP: In addition to the time limitations for TD 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.<br>SJDB: Depending upon the amount of PD awarded, SJD benefits have a maximum of $10,000.00, for injuries prior to 1/1/13. For injuries on or after 1/1/13, SJD benefits are capped at $6,000, regardless of the level of PD awarded. The voucher expires 2 years from the date of issue or 5 years from the date of injury, whichever is later |

**Medical issues**

**Medical issues**

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| 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 use 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, unless discharged from care with no need for further medical treatment, but must select a physician within the MPN. |
| Medical Fee Schedule | CA has an official medical fee schedule covering, but not limited to, 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 80% of the fee for the same procedure under the Medicare ambulatory payment classification facility (APC) fee schedule. Ambulance, durable medical equipment, laboratory and pathology fees are limited to 120% of the relevant Medicare 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. If the underlying drug is not listed then the reimbursement is at 83% of the average wholesale price (AWP) of the lowest priced therapeutically equivalent drug. |
| Managed Care | Medical Provider Networks must be approved by the state and are subject to regulatory review. Pharmacy Networks must comply with regulatory standards, though regulations have yet to be promulgated. |
| Other: Interpreter/Copy Service | Effective 7/1/15, there is a fee schedule for interpreting and photocopy fees. |
| Utilization Review | All medical treatment is 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. All UR decisions on or after 7/1/13, UR disputes are resolved through the Independent Medical Review (IMR) process. Decisions by the IMR are presumed correct for one year unless there is a material change in condition and can only be appealed under limited circumstances. |
| Treatment Guidelines | The Medical Treatment Utilization Schedule (MTUS) holds a statutory presumption of correctness, but all treatment must be in accordance to scientific, evidence-based, nationally recognized guidelines. |
| Generic Drug Substitution | The state mandates generic substitution, except when the prescribing physician indicates no substitution for medical reasons or there is a WCAB order. |
| Medical Mileage Reimbursement Rate | The current medical mileage reimbursement rate, effective 1/1/2017 is 53.5 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 may terminate medical treatment upon a finding by the treating or medical-legal physician that no further treatment is reasonably necessary. Interim Orders or 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 |

**Medical issues**

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| | a Stipulations With Request for Award (Stip), or a Compromise and Release (C&R). Medical issues involving ongoing treatment are usually resolved by Stipulation and Order. At the end of case, medical issues involving future medical care are resolved by Stipulation with Request for Award (Stip), or Compromise and Release (C&R).<br>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. SB863 clarifies that, once a chiropractor has reached the maximum 24 visit, he or she can no longer serve as a provider in any capacity, unless the administrator agrees in writing to allow additional services.<br>Effective 1/1/08, these caps do not apply to post-surgical treatment, 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 MTUS 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**

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| WC Hearing Docket Speed | Hearings (Mandatory Settlement Conferences) are set between 10 and 60 days from filing of a Declaration of Readiness (DOR). Certain issues call for an expedited hearing, to be set within 30 days of filing of the DOR. Formal hearings, or trials, are to be set within 75 days of the DOR.<br>With the enactment of SB 863, medical liens were under an injunction which caused delays in closing liens. The injunction is no longer in place and the activation fee is required now on all liens. If there was an older lien and no activation fee was paid by 1/1/16, they were dismissed as a matter of law.<br>Medical liens should be significantly reduced, due to greater lien filing requirements and fees, a shorter statute of limitations, and replacement of the WCAB with the IMR and IBR processes to resolve treatment and billing disputes. |
| Staff Counsel | Laura G. Chapman & Associates<br>11070 White Rock Road, Suite 250<br>Rancho Cordova, CA 95670<br>916-638-6358<br><br>Laura G. Chapman & Associates<br>6715 N. Palm Ave., Suite 110<br>Fresno, CA 93704<br><br>Laura G. Chapman & Associates<br>2107 N. 1st St., #640<br>San Jose, CA 95131<br><br>Bencivenga & Associates<br>21688 Gateway Center Drive, Suite 125 |

**Medical issues**

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| | Diamond Bar, CA 91765<br>909-612-3870<br><br>Bencivenga & Associates<br>9325 Sky Park Court \| Suite 230<br>San Diego, CA 92123<br>W: 858.616.6115<br><br>Dimaculangan & Associates<br>333 City Boulevard West Suite 250<br>Orange, CA 92868<br>714-922-1308<br><br>Trinidad & Associates<br>655 North Central Ave., Suite 2000<br>Glendale, CA 91203<br>818-502-6448 |
| 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 disease is the result of continuous exposure to harmful substances in the course of employment. Occupational disease, as the term is used in California, is a disease that in whole or in part was caused by work.<br>Occupational diseases and repetitive trauma can both be compensable in the CA workers' compensation system. The date of injury for both is the date the claimant first suffered disability and knew, or should have reasonably known, that the condition was industrial. |

**Other Issues**

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| 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.<br>Contribution can be obtained from a co-defendant, such as another employer or insurer, and against all benefits provided. Parties have one year from the date of approval of the settlement 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 3.0 in place. Administrators must file the FROI, SROI, Annual, and Final reports, as well as medical data, electronically with the state. FROI, SROI must be submitted within 10 business days of the date of claim administrator knowledge. Where liens exist and there are multiple bills for a lien claimant and liens are settled in one lump sum are to be reported utilizing one of six jurisdictional code values. |
| Penalties | Any unpaid or late indemnity benefit is subject to self-imposed 10% increase if |

**Other Issues**

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| | 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.<br>Undisputed non-electronic submitted medical treatment charges not paid within 45 calendar days of receipt of the bill (or 15 working days for electronic submissions) 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. Billing disputes for dates of service on or after 1/1/13 are to be resolved through the Independent Billing Review (IBR) process. Decisions by the IBR are presumed correct and can only be appealed under limited circumstances. |
| 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, changed 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. |
| Interpreter Certification | In order to qualify to be paid for interpreter services at hearings, depositions, arbitrations, medical treatment appointments and medical legal exams, interpreter must be certified. SB 863 requires the State Personnel Board to establish, maintain, administer, and publish annual an updated list of certified interpreters. Certified definition is listed under the State Personnel Board webpage: http://jobs.spbp.ca.gov/InterpreterListing/ or the California Courts webpage at http://courts.ca.gov/programs-interpreters.htm. |
| Office of Self- Insurance Plans (OSIP) Actuarial Reporting and Actuarial Based Security Deposit | Labor Code 3701 requires private self-insured employers, including self-insuring groups to post a security deposit with the department. SB 863 changes the calculations of those security deposits requiring the calculation of self-insurer's projected losses and expenses upon which the security deposit is based be reflected in a written actuarial report that projects ultimate liabilities of the self-insured employer at the expected actuarial confidence level. Report must include actuary who prepared the report. |
| Lien Activation/Filing Fees | Lien claimants are required to pay the $100 activation fee in order to appear at a hearing or file a Declaration of Readiness to Proceed (DOR) regarding a lien. If lien was not filed prior to 1/1/2014 lien claimants must submit a lien filing fee of $150 to the Division of Workers Compensation prior to attending a lien conference or hearing. Failure to pay the lien filing fee will result in the lien being invalid and will not be considered filed.<br>The following are exempt from filing fees: health care service plans, group disability insurers, self-insured employee welfare benefit plans, Taft-Hartley Health & Welfare Funds or a public funding that provided medical benefits. Lien filing fees can be refunded under certain conditions (see Title 8, California Code of Regulations § 10208.1) Lien filing fees will be allocated to the Workers Compensation Administration Revolving Fund to administer the Return to Work Fund established under SB 863.<br>The Division of Workers' Compensation ended its collection of the lien activation fees at midnight on December 31, 2015. Any liens not activated by that time were dismissed by operation of law - This pertains only to liens filed |

**Other Issues**

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| | prior to 01/01/2013. |
| In-State Adjusting Required | Not for insured accounts. Self-insured clients must prove “good cause” and receive prior approval from the Office of Self Insurance Plans. Out of state adjusting, is rarely approved. |
| 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.<br>Administrators who administer self-insured claims must hold a valid Certificate of Consent to Administer from Self-Insured Plans. |