Workers' Compensation 101

Created for PARMA by

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Contents

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Disclaimer

This information has been compiled to provide you with a brief, non-exhaustive, general overview of workers' compensation law. Please contact your attorney with case specific inquiries.

Workers' Compensation System

Workers' compensation is an administrative, non-fault system codified within the Labor Code. It functions without the aid of a jury through workers' compensation administrative law judges ("WCJs" or "ALJs") of the Division of Workers' Compensation ("DWC") of the State of California's Department of Industrial Relations ("DIR"), whose decisions may be reviewed by the seven-member, Governor-appointed Workers' Compensation Appeals Board ("WCAB"). Per Labor Code § 3202, the law is to be "liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." Injured workers may receive special, legislatively-enumerated benefits only. There are no damages for pain and suffering. Settlements must be reviewed and approved by a Judge.

Types of Injuries

Labor Code § 3208.1 defines two types of injuries: a specific and a cumulative.

Specific

A specific injury is one that occurs "as the result of one incident or exposure which causes disability and the need for medical treatment," (Labor Code § 3208.1). For example, injuries resulting from a slip and fall or a car accident would be a specific injury. In the case of a specific injury, the "date of injury" ("DOI") is considered the date on which the incident or exposure leading to the injury occurred (Labor Code § 5411).

Cumulative Trauma

A cumulative injury (generally referred to as a cumulative trauma or "CT") is one that occurs from "repetitive mentally or physically traumatic activities extending over a period of time," (Labor Code § 3208.1). For example, overuse injuries such as those resulting from keyboarding would be a cumulative trauma.

In the case of a cumulative trauma, the "date of injury" ("DOI") is defined by Labor Code § 5412 as, "that date upon which the employee first suffered *disability* therefrom and either *knew*, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment." (Emphasis added). The date of injury is much more difficult to identify in the case of a cumulative trauma. Therefore, it is considered a legal question reserved for the trier of fact (i.e. the Judge).

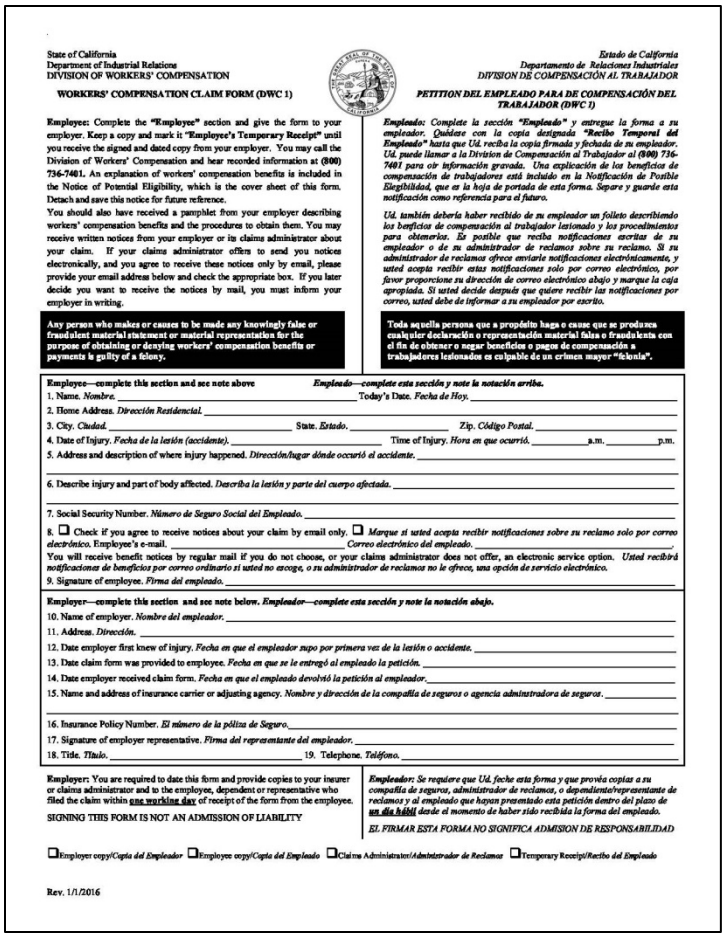
A cumulative trauma is generally identified in writing as a range of dates; for example, "January 1, 2015 through February 15, 2017." However, the date of injury is only that final day upon which

there was knowledge and disability. The range is considered the "cumulative trauma period." It may be any length of time as long as it is more than one day.

The cumulative trauma period should not be confused with the "liability period," which is defined by Labor Code § 5500.5 as one year prior to either (a) the date of injury, or (b) the last day of injurious exposure, whichever occurs first. Liability for a cumulative trauma injury may be shared by those employers that employed the injured worker within the one year liability period.

Reporting of an Injury

The Employer must provide the Injured Worker ("IW") with a claim form within one working day of receipt of notice (from any source) of the Injured Worker's injury. The claim form is identified as a "DWC-1." A copy is included to the right for reference. Downloadable copies may be found at the Division of Workers' Compensation ("DWC") website under "Forms."



State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.
You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al* **(800) 736-7401** *para oír información grabada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***
1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***
10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.
SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*
EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐Employer copy/*Copia del Empleador* ☐Employee copy/*Copia del Empleado* ☐Claims Administrator/*Administrador de Reclamos* ☐Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

Providing a claim form is important for a number of reasons, including ensuring prompt acceptance of legitimate claims and payment of benefits.

If the Employer fails to provide the claim form timely, a claims administrator may do so either within three days of learning of the injury for which a claim form was not properly provided or, if it cannot be determined if a claim form was properly provided, within 30 days of the claims administrator's knowledge of the claim.

The Injured Worker must complete and "file" the completed form with the Employer by mail or hand delivery.

Initial Handling

A claim may be accepted, delayed, or denied. If a claim is to be denied, the denial must be made within 90 days of the filing of a claim form. Otherwise, the claim will be presumed compensable pursuant to Labor Code § 5402(b). Denials may be for medical, legal, or factual reasons and may

follow an investigation. Labor Code § 5402(b) obliges the Employer/Insurance Company to authorize medical treatment up to $10,000 until the claim is formally accepted or denied.

In cases of public safety employees, there are a number of injuries that are presumed industrial subject to rebuttal. Those injuries include, but are not limited to, hernias, cancer, and low back injuries for individuals that are required to wear duty belts. See Labor Code § 3212 et seq.

Medical Treatment

Pursuant to Labor Code § 4600, the Employer/Insurance Company is obligated to provide medical treatment that is "reasonably required to cure and relieve the effects of" an accepted industrial injury. The Injured Worker is entitled to reimbursement for mileage associated with traveling to and from doctor's appointments necessary to treat an industrial injury.

Primary Treating Physician ("PTP") and Medical Provider Network ("MPN")

A single physician or facility is used to manage the medical treatment of a particular injured worker. That physician is referred to as the Primary Treating Physician ("PTP") and is subject to particular reporting requirements.

In some cases, the Injured Worker will have pre-designated a physician to act as his or her PTP pursuant to Labor Code § 4600(d). That physician must have agreed to be pre-designated.

Where there is no pre-designation, the Injured Worker should select a physician within the established Medical Provider Network ("MPN"), if one exists. The MPN is a list of physicians identified by the Employer/Insurance Company in advance from which the Injured Worker may choose a treater. In order to be valid in a specific case, there must be at least three physicians capable of treating the Injured Worker's injury within 15 miles or 30 minutes of the Injured Worker's home (Title 8 California Code of Regulations § 9767.5(a); *Soto v. Sambralio Packaging* (2016) Cal. Wrk. Comp. P.D. LEXIS). More information about Medical Provider Networks can be found at the following link: http://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html.

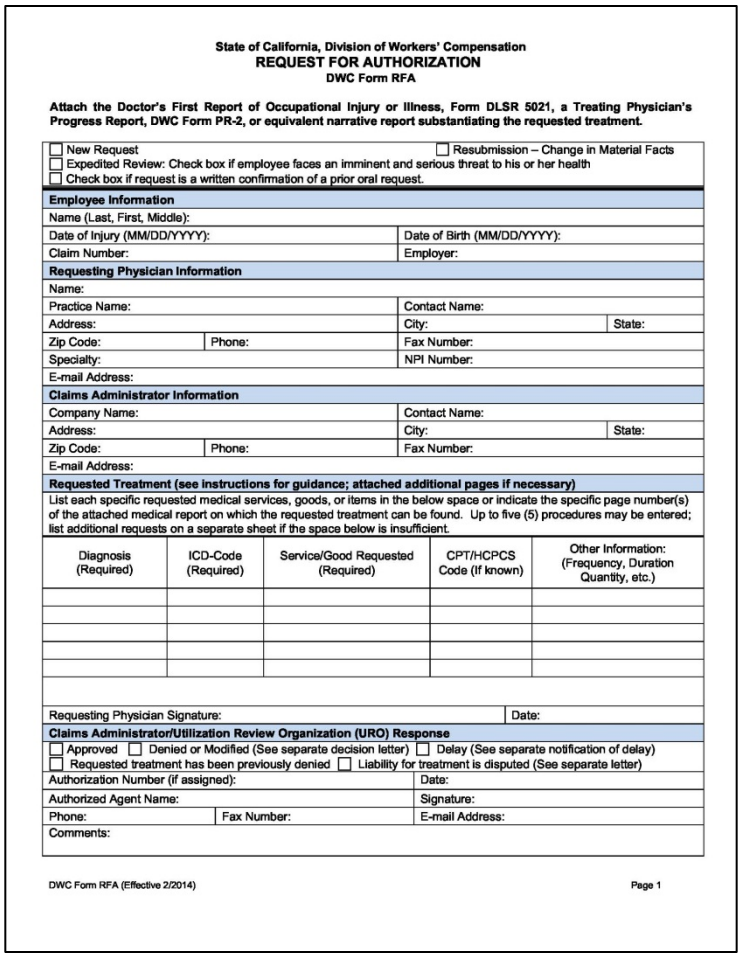
If an Employer/Insurance Company does not have an established Medical Provider Network or it is considered invalid in a particular case, the Injured Worker may select any physician to treat with so long as he or she is within "a reasonable geographic distance" from the Injured Worker's home. "Reasonable geographic distance" is subject to interpretation.

Per Labor Code § 4600(c), a chiropractor may only serve as Primary Treating Physician until the Injured Worker receives the maximum number of chiropractic visits allowed by Labor Code § 4604.5(c), which is 24 visits. The same statutory limit applies to physical therapy treatment.

Be aware that the Employer/Insurance Company may be liable for "compensable consequences" of an industrial injury. That may include adverse drug reactions from medication taken to relieve an industrial injury. It may also include injuries that are sustained while traveling to or from the doctor's office for an industrial visit.

Utilization Review ("UR")

Medical treatment is controlled by Labor Code § 4610, the Utilization Review process. It begins when a primary or secondary treater submits a Request for Authorization ("RFA") of medical treatment to the claims administrator.



State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	

Requesting Physician Information

Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			

Claims Administrator Information

Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature: Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (Effective 2/2014) Page 1

A response must be made within 5 days of receipt unless it is an expedited request (72 hours from receipt of RFA) or a retrospective request (30 days from receipt of all information necessary to make a decision).

The claims administrator may choose to approve, delay (when the RFA is incomplete), deny, or defer (when there is a non-medical issue such as a denied claim) the request. It may also forward the request to a medical reviewer, who may approve, delay (when the RFA is incomplete), modifiy, or deny the request.

Utilization Review's decision is valid for twelve months absent a change in circumstances.

Independent Medical Review ("IMR")

The Injured Worker has a right to seek Independent Medical Review of a modified or denied treatment request. For all claims with dates of injury on or after January 1, 2013, Independent Medical Review retains exclusive jurisdiction overall all treatment disputes as opposed to Judges, subject to some exceptions including untimely conduction of Utilization Review. When Independent Medical Review is pursued, an anonymous physician will review all relevant documents and determine whether to uphold or overturn the Utilization Review decision. Independent Medical Review's decision is final and binding for one year absent a change in circumstances.

Indemnity Benefits

There are three types of indemnity benefits: temporary total disability ("TTD"), temporary partial disability ("TPD"), and permanent disability advances. Public safety employees are entitled to additional benefits including full salary for a limited period under Labor Code § 4850.

Temporarily Totally Disability ("TTD")

A physician may determine that the Injured Worker cannot work in any capacity for a period of time. During that period, the Injured Worker is considered temporarily totally disabled or "TTD," and is entitled to receive indemnity benefits equal to two thirds of his or her Average Weekly Wage ("AWW") calculated over the 52 weeks preceding the injury.

TTD benefits cease when (1) the Injured Worker returns to work in any capacity, (2) the Injured Worker receives 104 weeks of temporary disability indemnity benefits whether total or partial within five years of the date of injury, or (3) the Injured Worker is deemed permanent and stationary ("P&S") or maximally medically improved ("MMI").

Temporarily Partially Disability ("TPD")

A physician may determine that the Injured Worker can work in a modified capacity. If he or she cannot work a full shift or a full workweek, temporary partial disability ("TPD") benefits or "wage loss" may be due. Pursuant to Labor Code § 4654, wage loss is two-thirds of the weekly loss in wages during the period of such disability.

Permanent Disability Advances ("PDAs")

When an Injured Worker is considered permanent and stationary ("P&S") or maximally medically improved ("MMI"), he or she has reached a point where he or she is unlikely to get better or worse with or without medical treatment in the period of one year. It is a medical question.

Once P&S or MMI status is reached, a physician will determine if the Injured Worker may be released to his or her "usual and customary occupation," which is that position which he or she worked at the time the injury occurred, or whether work restrictions need to be imposed. The Employer may or may not be able to accommodate the recommended work restrictions.

Once an Injured Worker has been deemed P&S or MMI, a reasonable estimation of permanent disability indemnity must be advanced (reserving 15% for attorney's fees if applicable) unless (a) the Injured Worker is working for the same Employer earning at least 85% of his or her pre-injury wages or (b) the Injured Worker is working for a new employer earning at least 100% of his or her pre-injury wages (Labor Code § 4650(b)(2)).

In cases with dates of injury prior to January 1, 2013, the Employer must make an offer of regular, modified, or alternative work within 60 days of the Injured Worker's permanent and stationary date in order to take a 15% discount in permanent disability due, which is called a "bump down." If no such work is offered, the Injured Worker may be entitled to a 15% increase in benefits, which is referred to as a "bump up."

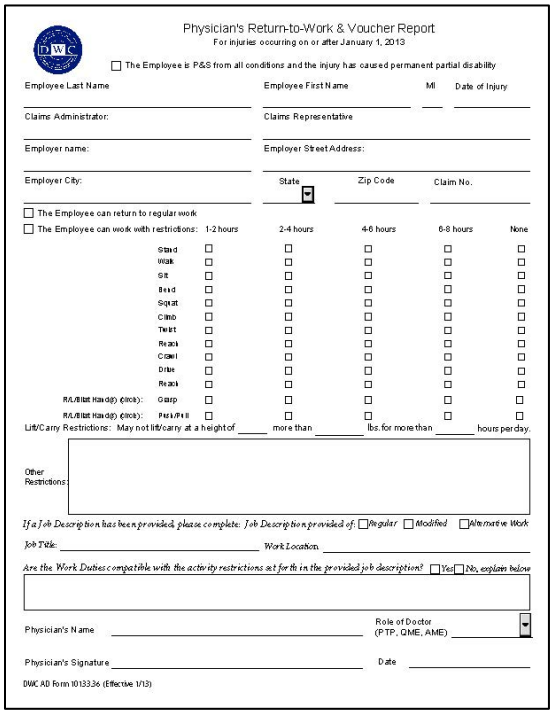
Supplemental Job Displacement Benefits

This is typically referred to as "the Voucher." It is a specific amount of money that the Injured Worker may draw from for specific re-training purposes. It is only due when: (1) the injury resulted in permanent disability, (2) the Injured Worker did not timely return to work, and (3) an offer of modified work was not timely made. Additional information is available at the following link: https://www.dir.ca.gov/dwc/sjdb/SJDB_FAQ.html.

The rules vary depending on the date of injury:

Pre-1/1/2013: A Voucher is due if the Employer does not make an offer of modified work within 60 days of the termination of temporary disability benefits, which the Injured Worker fails to accept. The Voucher can be settled. If not settled, the Voucher must issue within 25 days of an Award of permanent disability. It does not expire. The amount varies depending upon the level of permanent disability awarded.

Post-1/1/2013: A Voucher is due if the Employer does not make an offer of modified work within 60 days of receipt of a completed Physician's Return to Work & Voucher Report (see below). The Voucher cannot be settled. It must issue within 20 days after the 60 day time period to make an offer expires. The Voucher itself does expire within two years of issuance or five years from the date of injury, whichever is sooner. When due, the amount is always $6,000. The Injured Worker may also submit the signed Voucher to the State of California's "Return to Work Fund," which will pay him or her an additional $5,000 in cash. (The funds for that program will eventually be depleted).



Physician's Return-to-Work & Voucher Report

For injuries occurring on or after January 1, 2013

☐ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name | Employee First Name | MI | Date of Injury

Claims Administrator: | Claims Representative

Employer name: | Employer Street Address:

Employer City: | State | Zip Code | Claim No.

☐ The Employee can return to regular work

☐ The Employee can work with restrictions:

	1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Reach	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐
Reach	☐	☐	☐	☐	☐
R/L/Bilat Handg (circle):	Grasp	☐	☐	☐	☐	☐
R/L/Bilat Handg (circle):	Pinch/Pull	☐	☐	☐	☐	☐

Lift/Carry Restrictions: May not lift/carry at a height of ____ more than _____ lbs. for more than _____ hours per day.

Other Restrictions:

If a Job Description has been provided, please complete: Job Description provided of: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location* _____

Are the Work Duties compatible with the activity restrictions set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

Physician's Name _____ Role of Doctor (PTP, QME, AME) _____

Physician's Signature _____ Date _____

DWC AD Form 10133.36 (Effective 1/13)

Med-Legal Evaluations

A med-legal evaluator may be a Primary Treating Physician ("PTP"), Qualified Medical Evaluator ("QME"), or Agreed Medical Evaluator ("AME") (represented cases only). Specific rules must be followed to obtain a med-legal evaluator and to communicate with med-legal evaluators. Overall, they exist to determine various issues including the compensability of a claim, diagnoses, periods of temporary disability, permanent disability, apportionment, future medical treatment, and work restrictions.

The opinions of the med-legal physician must rise to the level of "substantial medical evidence." Case law has made multiple attempts to define that term. Generally, it is understood to be opinions that are:

- based on a correct legal theory (See *Zemke v. WCAB* (1968) 68 Cal.2d 794),
- that are not based on "surmise, speculation, conjecture or guess" (See *Garza v. WCAB* (1970) 3 Cal.3d 312),
- that are based upon an adequate medical history or examination (See *West v. IAC* (1947) 79 Cal. App. 2d 711), and
- that are made within a "reasonable degree of medical probability." (See *Escobedo v. Marshalls* (2007) 70 Cal. Comp. Cases 604).

If opinions do not qualify as "substantial medical evidence," they may not be relied upon and in some circumstances may warrant a replacement med-legal evaluator.

Rating

A med-legal report is most important for determining an Injured Worker's level of permanent disability impairment using a book titled the American Medical Association ("AMA") Guides. The med-legal evaluator should utilize the instructions within that book to provide a numeric estimate of the Injured Worker's impairment in terms of "whole person impairment" ("WPI").

Once WPI is determined, the Disability Evaluation Unit ("DEU"), a private rater, a trained claims adjuster, or an attorney can then "rate" the Injured Worker's injury using the Permanent Disability Rating Schedule. The Schedule adjusts the WPI by accounting for the type of injury, the occupation, and the Injured Worker's age, to produce a percentage of permanent disability. A copy of that schedule can be found in the Labor Code or at the following link: http://www.dir.ca.gov/dwc/pdr.pdf.

The rating should take in to account the med-legal evaluator's opinions, if any, on apportionment. Permanent disability may be apportioned to prior Awards under Labor Code § 4664 or to pre-existing conditions, asymptomatic conditions lit up by the industrial injury, and many other factors under Labor Code § 4663. It may also be apportioned between dates of injury per *Benson v WCAB* (2009) 170 Cal. App. 4th 1535. The idea is that the Employer should only be liable for the percentage of permanent disability directly caused by the injury "arising out of and in the course

of employment." (Labor Code § 4664(a)). However, apportionment is a legal issue to be determined by the trier of fact relying on substantial medical evidence.

When an injury is rated, a "rating string" is produced that may look like the following:

100%(15.03.01.00-7[1.4]10-360G-12-13) = 13% Permanent Disability

The resulting permanent disability percentage warrants a particular number of weeks of permanent disability indemnity payments as determined by the Permanent Disability Ratings Chart, which is available in the Labor Code. Payments are made at a rate equal to the Injured Worker's temporary disability rate, subject to the permanent disability minimum and maximums allowed for the year associated with that Injured Worker's date of injury. The rate minimums and maximums are outlined at the following link:

https://www.dir.ca.gov/dwc/workerscompensationbenefits.htm

Resolution

There are a number of ways to resolve a claim. The preferred method will depend on the primary issue or issues to be resolved and the specific facts of the case. The most commonly utilized options are outlined, below:

Stipulated Award

This method of resolution allows the parties to agree on the body parts injured and the Injured Worker's level of permanent disability, which are generally the primary issues. Payment is made at a weekly rate paid bi-weekly retroactive to the permanent and stationary date or the last day of temporary disability paid and continuing until the allowed weeks of payment are exhausted. It leaves open the Injured Worker's right to obtain medical treatment for the industrial injury or injuries through the workers' compensation system, albeit subject to the Utilization Review and Independent Medical Review processes explained above. That does create potential exposure for additional compensable consequence claims. The Injured Worker also retains a right to file a Petition to Reopen his or her claim within five years of the date of injury if he or she suffers new and further disability, including a new compensable consequence.

Compromise & Release

This method of resolution generally concludes all aspects of the case, including the right to future medical treatment and the right to reopen. It is a negotiated amount that is generally paid to the Injured Worker by annuity or in a lump sum less permanent disability advances already paid and attorney's fees, if applicable. It must be approved by a Judge who must review it for adequacy.

Depending upon the gross amount of the Compromise &Release, if the Injured Worker is receiving Medicare benefits, has applied to receive Medicare benefits, is age-eligible to receive Medicare benefits, or otherwise expected to receive Medicare benefits within 30 months, Medicare's interests must be taken into account before the Compromise & Release may be

approved by a Judge. The goal is to reduce the likelihood that Medicare will need to pick up medical benefits for an industrial injury at some point in the future by explicitly valuing the likely cost of medical needs for an industrial injury prior to settlement.

One may adequately take Medicare's interests into consideration by including an "allocation" in the settlement agreement or by obtaining a "Medicare Set-Aside," ("MSA") which may or may not need to be approved by the Centers for Medicare & Medicaid Services ("CMS"). The appropriate method depends upon the Injured Worker's Medicare beneficiary status and the amount of the gross settlement.

An MSA is an itemized projection of the likely future medical care costs associated with an industrial injury. It may be self-administered or administered by an independent, third party for a fee. In either scenario, a detailed accounting must be kept as the funds are used for medical treatment for the industrial injury. Once it is depleted, the Injured Worker or its administering agency may present Medicare with its proof that the funds were appropriately used and ask that it pick up medical benefits for the injury from that point forward.

Mediation

The parties may choose to attend a facilitated settlement meeting with an objective third party in order to reach a settlement agreement.

Arbitration

The parties may choose to arbitrate any issue with rights to appeal to the Workers' Compensational Appeals Board. Some issues must be arbitrated including insurance coverage and contribution pursuant to Labor Code § 5275(c).

Trial

The parties may proceed to trial on any issue not subject to mandatory arbitration. They may present evidence including documents and witness testimony. The Judge will prepare a Summary of Evidence following the trial and ultimately issue a Findings & Award with his or her decision. Both parties retain rights to appeal by filing a Petition for Reconsideration to the Workers' Compensation Appeals Board. From there, appeals may be made by Petition for Writ of Review to the Court of Appeal and subsequently by Request for Review by the Supreme Court.

Liens

Some people or entities that provide value to a party in a workers' compensation case without payment for the same may file a lien for a small fee or free, if exempt. For example, the Employment Development Department ("EDD") may pay State Disability Indemnity ("SDI") to an Injured Worker, for which it may be entitled reimbursement. Other examples include liens filed by physicians, photocopy services, or private medical insurance companies. Some liens, including EDD and child support liens, must be resolved at the time of settlement. Otherwise, they may be disposed of after the "case-in-chief" resolves by settlement or by trial.

Index of Workers' Compensation Terms & Acronyms

Term	Acronym (if applicable)	Definition
Applicant		The person or entity that files an "Application for Adjudication" at the Workers' Compensation Appeals Board. It is generally the Injured Worker, but in some situations it may be the Employer, the Insurance Company, or the Claims Administrator.
Applicant's Attorney	AA	The legal representative of the Applicant. Generally, that is the Injured Worker's attorney. However, in some situations it can be the attorney for the Employer, the Insurance Company, or the Claims Administrator.
American College of Occupational & Environmental Medicine	ACOEM	A professional organization that create medical treatment guidelines.
American Medical Association Guides	AMA Guides	A detailed book containing instructions to measure impairment caused by various injuries that is relied upon for determining permanent disability in workers' compensation cases.
Americans with Disabilities Act	ADA	A federal statute that prohibits discrimination of persons with disabilities.
Activities of Daily Living	ADL	A term used to describe normal physical activities including, but not limited to, bathing, dressing, and walking. In context, the acronym is pronounced "ADLs."
Administrative Law Judge	ALJ	A judge that presides over cases involving administrative law. (See also: Workers' Compensation Judge or "WCJ").
Arising Out of and Occurring in the Course of Employment	AOE/COE	This is a term of art used in the Labor Code to describe an injury that is caused by employment. (See also: Industrial Injury).
Agreed Vocational Evaluator	AVE	This is a professional that both parties agree to use to determine an Injured Worker's skills as they concern ability to compete for jobs in the labor market.
Average Weekly Wage	AWW	The typical amount of earnings obtained by an Injured Worker in the 52 weeks preceding his or her injury. This is also referred to as "Average Weekly Earnings" or "AWE".
Compromise & Release	C&R	A settlement agreement that generally seeks to resolve all issues including right to medical treatment.
Cost of Living Adjustment	COLA	Adjustments made to supplemental income benefits such as permanent disability indemnity to account for the effects of inflation.
Cumulative Trauma	CT	A type of injury that occurs due to repetitive motion

		or ongoing exposure over time.
Disability Evaluation Unit	DEU	An office within the Workers' Compensation Appeals Board that exists to determine permanent disability ratings by evaluating med-legal reports.
Date of Injury	DOI	The date the incident or exposure occurred that led to the claimed injury or condition. There are specific rules as DOI relates to cumulative trauma claims, see above.
Declaration of Readiness to Proceed	DOR or DR	A pleading that a party files with the Workers' Compensation Appeals Board in order to set a matter for a hearing on a specific issue or issues.
Division of Workers' Compensation	DWC	A sector of the State of California's Department of Industrial Relations that monitors the administration of workers' compensation claims and provides administrative and judicial services to resolve workers' compensation related disputes.
Death Without Dependency Unit	DWDU	A sector of the State of California's Department of Industrial Relations that handles the administration of benefits to individuals that died without dependents and challenges dependency claims raised by individuals claiming to be a dependent of the Injured Worker.
Employer	ER	Generally this is used to describe the entity that employed the Injured Worker at the time of the injury.
Employment Development Department	EDD	An agency that exists to administer benefits including unemployment benefits and state disability benefits.
Findings & Award	F&A	A Judge's decision following a trial that generally awards permanent disability benefits to the Injured Worker.
Findings & Order	F&O	A Judge's decision following a trial that generally does not include benefits to the Injured Worker.
Future Earning Capacity	FEC	An individual's ability to produce income in the future.
Future Medical Care	FMC	The need for ongoing treatment to cure or relieve the effects of an industrial injury.
Global Assessment of Functioning	GAF	A score used to quantitate an individual's psychiatric injury.
Industrial		A term used to describe an injury that arises out of and in the course of employment.
Information & Assistance Officer	I&A	An individual employed by the Division of Workers' Compensation to provide support and education primarily to unrepresented injured workers.
Injured Worker	IW	An employee that has sustained a bodily or psychiatric injury within the scope of employment. If they have filed an Application for Adjudication, they

		are generally referred to as Applicants (see above). However, if they do not so file, they are properly identified as the Injured Worker.
In Pro Per		An unrepresented injured worker.
Independent Medical Examination	IME	A court-appointed med-legal evaluator.
Lower Extremity	LE	This term is generally used to identify the body parts existing from the hips to the toes.
Maximum Medical Improvement	MMI	The point at which an injured worker's condition cannot be improved further with or without additional medical treatment within the scope of one year. (See also: Permanent & Stationary).
Medical Provider Network	MPN	A pre-established group of physicians selected by the Employer/Insurance Company within which the Injured Worker must seek treatment.
Medicare Set-Aside	MSA	An itemized projection of future medical care needs associated with an injury or injuries.
Medical Treatment Utilization Schedule	MTUS	A set of guidelines for treating various injuries or ailments.
Permanent & Stationary	P&S	The point at which an injured worker's condition cannot be improved further with or without additional medical treatment within the scope of one year. (See also: Maximum Medical Improvement).
Permanent Disability	PD	In workers' compensation, this generally refers to the percentage by which a human body has been irreversibly altered due to an industrial injury or injuries.
Permanent Disability Advances	PDAs	Permanent disability indemnity that is paid prior to an Award.
Permanent Disability Rating Schedule	PDRS	A set of guidelines for converting whole person impairment to permanent disability by accounting for body part, occupation, and age.
Permanent Partial Disability	PPD	Less than complete (100%) disability.
Permanent Total Disability	PTD	Complete (100%) disability.
Primary Treating Physician	PTP	The principal physician managing an injured worker's care for an industrial injury or injuries.
Return to Work	RTW	An injured worker's status as it relates to continuing to work for the Employer in the capacity he or she did prior to the injury or another capacity.
Subpoena Duces Tectum	SDT	An order to produce documents such as medical records.
Subsequent Injuries Benefits Trust Fund	SIBTF	A source of additional compensation for injured workers who already had a disability or impairment at the time of injury.
Self-Imposed Penalty	SIP	A 10% increase in benefits added to benefits due

		when they are paid late, but prior to an Order.
Statute of Limitations	SOL	Statutory timelines for completing tasks including filing a claim.
Temporary Disability	TD	The inability to work due to an industrial injury.
Temporary Partial Disability	TPD	The inability to work the same amount of hours or in the same capacity as the injured worker could prior to the industrial injury.
Third Party Administrator	TPA	An organization that administers claims on behalf of an insurance company of permissibly self-insured employer.
Temporary Total Disability	TTD	The inability to work in any capacity for a period (generally temporary) of time due to an industrial injury.
Usual & Customary Occupation	U&C	The position an injured worker held at the time of his or her injury.
Vocational Rehabilitation	VR	The process through which an individual's functional, psychological, and cognitive abilities are assessed to determine whether he or she can return to employment.
Workers' Compensation	WC	A system that compensates workers that are injured within the scope of their employment.
Workers' Compensation Insurance Review Board	WCIRB	An organization that monitors workers' compensation insurers.
Wage Loss	WL	Compensation for earnings loss resulting from an industrial injury.
Whole Person Impairment	WPI	A term used by the AMA Guides to quantify an injury, which is rated out to permanent disability using the Permanent Disability Ratings Schedule.