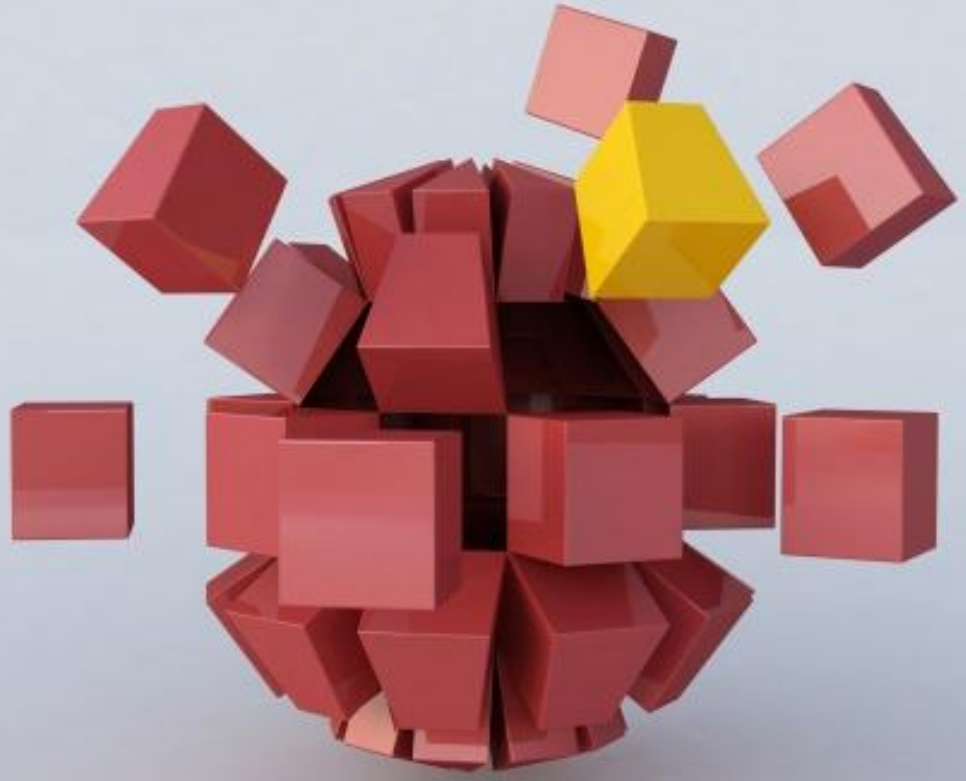
The Building Blocks of a California Workers' Compensation Program



The Foundation

1. Workers' Compensation – A Social Benefit
   The history and evolution of the system
2. Who is covered?
   The Employer and Employee Relationship
3. Employer Responsibilities
   The pre and post injury responsibilities
4. The Injury
   What constitutes an injury, determining AOE/COE.
5. What are the benefits?
   Benefits paid to, on behalf of, or administered for the employee.

The Foundation

6. Medical Benefits
   Treatment, medical-legal and dispute processes.
7. Settlement
   Understanding the settlement options
8. Other Considerations
   Subrogation, Fraud and Ancillary Issues
9. Financing the Risk
   Understand the general risk financing options
10. A Healthy Workers' Compensation Program
    Tips and Tricks

Workers' Compensation – A Social Benefit

- The First Legislation in California
- No Fault
- Exclusive Remedy
- Liberal Construction
- Benefit Delivery System

Who is an Employee and Employer?

- Employee – Every person who performs a service for another under any appointment or contract of hire or apprenticeship, expressed or implied, oral or written, whether lawfully of unlawfully employed
  - Volunteers, Elected Officials, Students, Contractors, Prisoners

- Employer – Any person or entity that engages the services of a “natural person”
  - General, Special, Co-Employer, Non-Profits

Employer Pre-Injury Requirements

- Posting Notice
- Time of Hire Notice
- Pre-designation Process
- Injury Prevention Programs

Employer Post-Injury Requirements

- Forms and Paperwork
- Immediate access to treatment
- Report the injury timely
- Prompt gathering of information
  - Witnesses
  - Scene photos

Claim Form (DWC-1)

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 as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

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 oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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.

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 occurió 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. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

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

6/10 Rev.

Employer's Report of Injury (Form 5020)

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

York RSG

PO Box 619079 Roseville, CA 95661
(909) 942-4900 Fax: (866) 548-2637

OSHA Case No. _____ ☐ Fatality

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

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME | 1A. POLICY NUMBER | DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number, Street, City and Zip) | 2A. PHONE NUMBER | Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number, Street, City and Zip) | 3A. LOCATION CODE | Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. | 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. | Industry
6. TYPE OF EMPLOYER ☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____ | | Occupation

INJURY OR ILLNESS

7. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy) | 8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M. | 9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M. | 10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy) | Sex
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO | 12. DATE LAST WORKED (mm/dd/yy) | 13. DATE RETURNED TO WORK (mm/dd/yy) | 14. IF STILL OFF WORK, CHECK THIS BOX ☐ | Age
15. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO | 16. SALARY BEING CONTINUED? ☐ YES ☐ NO | 17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy) | 18. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy) | Daily hours
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning | | | | Days per week
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street and City) | 20A. COUNTY | 21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | | Weekly Hours
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop. | 23. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO | | | Weekly wage
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold. | | | | County
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck. | | | | Nature of injury
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY. | | | | Part of body / Source
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City and Zip) | 27A. PHONE NUMBER | | | Event
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ YES ☐ NO IF YES THEN, NAME AND ADDRESS OF HOSPITAL (Number, Street, City and Zip) | 28A. PHONE NUMBER | 29. EMPLOYEE TREATED IN EMERGENCY Room? ☐ YES ☐ NO | | Sec. Source / Extent of injury

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29(b)(2)(E)2.
NOTE: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

EMPLOYEE

30. EMPLOYEE NAME | 31. SOCIAL SECURITY | 32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City and Zip) | | 33A. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE | 35. OCCUPATION (Regular job title - NO initials, abbreviations or numbers) | 36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours | 37A. EMPLOYMENT STATUS (check applicable status at time of injury) ☐ regular full-time ☐ part-time ☐ temporary ☐ seasonal | 37B. Under what class code of your policy were wages assigned?
38. GROSS WAGES/SALARY $_____ per* _____ | 39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $_____ per* _____ ☐ NO

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim, and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

Completed by (type or print)	Signature	Title	Date (mm/dd/yy)

FORM 5020 (REV. 7) June 2002

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

MPN Pamphlet

Welcome to WellComp

Your employer has elected to provide you with the choice of a broad scope of medical services for work-related injuries and illnesses by implementing a Medical Provider Network (MPN), called WellComp. WellComp delivers quality medical care through your choice of a provider who is part of an exclusive network of healthcare providers, each of whom possess a deep understanding of the California workers' compensation system and the impact their decisions have on you. Your employer has received the approval from the State of California to cover your workers' compensation medical care needs through the WellComp Network. You are automatically covered by the WellComp Network if your date of injury or illness is on or after your employer's implementation date and if you have not properly pre-designated a personal physician prior to your injury or illness.

In the event that you have an injury or illness, please complete the front of this card and carry it with you to present to your medical service providers for access to care.

This card is not required to receive medical services.

This employee is covered by the WellComp Network for workers' compensation medical care. Possession or use of this card does not guarantee eligibility for benefits. Treatment must be furnished or referred by a WellComp medical provider with the exception of emergency care or necessary treatment while the employee is out of the state of California. All treatment requires pre-authorization except for emergency care.

For treatment authorization contact WellComp Provider Services.
For WellComp Patient Services:
(909) 608-7171 or (800) 544-8150
fax: (909) 931-2151

For emergency care or necessary treatment while the employee is outside of the state of California, please notify WellComp to facilitate authorization, billing, and payment, as well as transfer of care.

Access to Medical Care

Initial Care

In case of an emergency, you should call 911 or go to the closest emergency room.

In the event that you experience a work-related injury or illness, immediately notify your supervisor and obtain medical authorization from your employer to designate an initial care provider within the network. If you are unable to reach your supervisor or employer, please contact the patient services department at WellComp.

Subsequent Care

If you still need treatment following your initial evaluation, you may be treated by a physician of your choice, or the initial physician may refer you to a medically and geographically appropriate specialist within the network who can provide the appropriate treatment for your injury or condition. For a directory of providers, please visit www.WellComp.net or call WellComp Patient Services.

Emergency Care

In an emergency, defined as a medical condition starting with the sudden onset of severe symptoms that without immediate medical attention could place your health in serious jeopardy, go to the nearest healthcare provider regardless of whether they are a WellComp participant. If your injury is work-related, advise your emergency care provider to contact WellComp to arrange for a transfer of your care to a WellComp provider at the medically appropriate time.

Hospital and Specialty Care

Your primary treating provider in the WellComp Network will make all of the necessary arrangements and referrals for specialists, inpatient hospital, outpatient surgery center services, and ancillary care services.

Choosing a Treating Physician

If you still require treatment after your initial evaluation with your employer's designated provider, you may access the WellComp Directory and select an appropriate physician of your choice who can provide the necessary treatment for your condition or illness. For assistance determining physician options, please contact the WellComp Patient Services Department or discuss your options with your initial care provider.

Scheduling Appointments

If you are having difficulty scheduling an appointment with your initial provider or subsequent provider, please contact your WellComp Patient Services Department.

Changing Primary Treating Physician

If you find it necessary to change your treating physician and it is determined that you require ongoing medical care for your injury or illness, you may select a new physician from the WellComp Directory and schedule an appointment. Once your appointment is scheduled, immediately contact WellComp Patient Services who will then coordinate the transfer of your medical records to your new provider.

Obtaining a Specialist Referral

As long as you continue to require medical treatment for your injury or illness, there are alternatives for obtaining a referral to a specialist:

1. Your primary treating provider in the WellComp Network can make all of the necessary arrangements for referrals to a specialist. This referral will be made within the network or outside of the network if needed.
2. You may select an appropriate specialist by accessing the WellComp Directory.
3. You may contact WellComp Patient Services who can help coordinate necessary arrangements.

Continuity of Care

What if I am being treated by a WellComp doctor and the doctor leaves WellComp?

Your employer has a written **"Continuity of Care"** Policy that may allow you to continue treatment with your doctor if your doctor is no longer actively participating in WellComp.

If you are being treated for a work-related injury in the WellComp Network and your doctor no longer has a contract with WellComp, your doctor may be allowed to continue to treat you if your injury or illness meets one of the following conditions:

- **(Acute)** A medical condition that includes a sudden onset of symptoms that require prompt care and has a duration of less than 90 days.
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues without full cure or worsens and requires ongoing treatment over 90 days. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN contract termination date.

If any of the above conditions exist, WellComp may require your doctor to agree in writing to the same terms he or she agreed to when he or she was a provider in the WellComp Network. If the doctor does not, he or she may not be able to continue to treat you.

If the contract with your doctor was terminated or not renewed by WellComp for reasons relating to medical disciplinary cause or reason, fraud or criminal activity, you will not be allowed to complete treatment with that doctor. For a copy of the Continuity of Care policy, please visit www.WellComp.net or call WellComp Patient Services.

Transfer of Ongoing Care

What if you are already being treated for a work-related injury before the WellComp Network begins?

Your employer has a **"Transfer of Care"** policy which describes what will happen if you are currently treating for a work-related injury with a physician who is not a member of the WellComp Network.

If your current treating doctor is a member of WellComp, then you may continue to treat with this doctor and your treatment will be under WellComp. Your current doctor may be allowed to become a member of WellComp.

If your current treating doctor is not or is not allowed to become a member of WellComp, then your physician may make referrals to providers within or outside the MPN.

You will not be transferred to a doctor in WellComp if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days.
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues without full cure or worsens over 90 days. You may be allowed to be treated by your current treating doctor for up to one year from the date of receipt of the notification that you have a serious chronic condition.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less. Treatment will be provided for the duration of the terminal illness.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date.

Care Transfer Disputes

If WellComp is going to transfer your care and you disagree, you may ask your treating doctor for a report that addresses whether you are in one of the categories listed above. Your treating physician shall provide a report to you within twenty calendar days of the request. If the treating physician fails to issue the report, then you will be required to select a new provider from within the MPN.

If either WellComp or you do not agree with your treating doctor's report, this dispute will be resolved according to Labor Code Section 4062. You must notify WellComp Patient Services Department, if you disagree with this report.

If your treating doctor agrees that your condition does not meet one of those listed above, the transfer of care will go forward while you continue to disagree with the decision.

If your treating doctor believes that your condition does meet one of those listed above, you may continue to treat with him or her until the dispute is resolved. For a copy of the Transfer of Care policy, please visit www.WellComp.net or call WellComp Patient Services.

The Injury Defined

- Definition - Any injury or disease arising out of employment/in the course of employment, including injuries to artificial members, hearing aids, eyeglasses, and medical braces of all types.

- AOE/COE – Arising Out of/Course of Employment

- Types of Injury:
  - Specific Injury: Occurring as the result of one incident or exposure which causes disability or need for medical treatment.

  - Continuous/Cumulative Trauma: Occurring as repetitive mentally or physically traumatic activity extending over a period of time, the combined effects of which causes a disability or need for treatment

Statutory Defenses

- Altercation/Initial Physical Aggressor
- Self-Inflicted Injury
- Intoxication
- Horseplay
- Suicide
- Commission of a Felony
- Off Duty Recreational Activity
- Psychiatric Injury
  - Less than 6 months employment
  - Predominant cause
  - Post-termination/Layoff
  - Good Faith Personnel Actions

AOE/COE Exceptions

- Going and Coming
- Special Errand
- Zone of Danger
- Vanpool
- Bunkhouse Rule
- Material Deviation
- Commercial Travel

Investigation

- Initial Claim Contact (Three Point Contact)
  - Usually completed by the claims examiner.
- Delay of Claim (Labor Code §5402)
  - Formal delay of claim. Allows ninety (90) days to determine compensability. Responsible for medical treatment during delay period up to $10,000
- Formal Statement Process

Benefits

- Benefit types
  - Medical Treatment: To cure and/or relieve the effects of the industrial injury.
  - Temporary Total/Partial Disability: Temporary wage replacement benefit while recovering from effects of industrial injury. Can be paid as part of salary continuation, education code and/or Labor Code 4850 benefit. Current maximum rate is $1,103.29 per week.
  - Permanent Disability: Compensation for permanent residuals of industrial injury. Percentages range from 0% to 100%; life pension benefits are applicable for permanent disability ranges 70% through 99%.
  - Supplemental Job Displacement Benefit: Retraining voucher.
  - Death Benefit: Payable to dependent(s) in the event of industrially related death of employee.

Transitional Duty

- Benefits of Return-to-Work (RTW) program
  - Savings of Temporary Disability Benefits
  - Continued employee productivity
  - Faster recovery
  - Lesser chance for litigation
  - Lower total claim cost

Medical Treatment

- Primary treating physician
  - Coordinates treatment
  - Reports on temporary and permanent disability status
- Medical Provider Networks (MPN)
  - Lifetime medical control
- Treatment may be subject to Utilization Review
  - Medical necessity
  - Determination may take up to 14 days
- Independent Medical Review (IMR)
  - Resolution process for treatment disputes
- Medical-Legal Examinations
  - Agreed or Panel Qualified Medical Examinations

Settlement

- Stipulations with Request for Award
  - Usually leaves future medical provisions open
- Compromise and Release
  - Usually settles all liability
  - Rarely leaves future medical provisions open
- Findings and Order (F&O)
  - Take nothing, no benefits awarded, after case is submitted for decision at trial
- Findings and Award (F&A)
  - Judge orders benefits, after case is submitted for decision at trial
- Global Settlement
- Early Settlement Opportunities

Other Considerations

- Subrogation – Recovery of claim costs against at-fault third party
  - Six month statute of limitations against governmental agencies, two years against all others
- Fraud – Intentional misrepresentation to gain benefits
- ADA/FEHA
  - Interactive Process
- Civil Lawsuits
  - Harassment
  - Discrimination
- CalOSHA
  - OSHA logs
  - Required immediate reporting to OSHA

Financing the Risk

- Risk Financing History and Philosophy
  - Insurance
  - Self-Insurance
  - Pooling
- Departments and Agencies Involved in Managing Claims
  - Third Party Administrator (TPA)
  - Insurance Company Claims Department
  - In-House Staff
  - Defense Counsel
  - Medical Providers
  - Investigators
  - Risk Manager/Loss Control Specialist
  - Executive Board
  - Claims/Coverage Committee

A Healthy Workers' Compensation Program

- Injury and Illness Prevention Program
- Report injury timely
- Participate in the investigation process
- Implement RTW program
- Report red flags
- Keep communications flowing
- Stay involved

- Jeff Rush, Workers' Compensation Program Manager
  California JPIA

- Jen Hamelin, Workers' Compensation Claims Manager
  CSAC

- De Ann Wagner, Assistant Vice President-Claims
  York Risk Services Group