Understanding Worker’s Compensation
Resident and Fellow Primer

Dori Cage, M.D.
San Diego Hand Specialists
Confusing Vocabulary:

- AOE
- COE
- P&S
- TTD
- TPD
- MMI
- QIW
- Alamaraz/Guzman
- IMR-Maximus
- DWC
**Report Requirements**

- First Report of Injury
- PR2
- RFA
- PR4/ PS Report
- QME
- AME
- Peer to Peer
- Appeals

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**STATE OF CALIFORNIA**

**DOCTOR’S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer’s workers’ compensation insurance carrier or the insured employer. Failure to file a timely doctor’s report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

**1. INSURER NAME AND ADDRESS**

**2. EMPLOYER NAME**

**3. Address**

**4. Nature of business (e.g., food manufacturing, building construction)**

**5. PATIENT NAME** (first name, middle initial, last name)

**6. Sex**

**7. Date of Birth**

**8. Address: No. and Street**

**9. Telephone number**

**10. Occupation (Specific job title)**

**11. Social Security Number**

**12. Injured at: No. and Street**

**13. Date and hour of injury or illness**

**14. Date last worked**

**15. Date and hour of first examination or treatment**

**16. Have you (or your office) previously treated patient? Yes No**

**17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.**

**18. SUBJECTIVE COMPLAINTS**

**19. OBJECTIVE FINDINGS**

**20. DIAGNOSIS**

**21. Are your findings and diagnosis consistent with patient’s account of injury or illness? Yes No**

**22. Is there any other condition that will impede or delay patient’s recovery? Yes No**

**23. TREATMENT RENDERED**

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**FORM WFC-20**
Different Systems

- California Workers Compensation
- Federal Workers Compensation
- Jones Act
- Longshore Workers
- Other States

• All workers are covered including household workers, undocumented workers and some prison inmates
Historic Compromise

• No Fault:
  • Employer required to pay for treatment regardless of who caused injury if it is work related

• Assumed and Fixed Benefits:
  • Injury and death benefit amounts are fixed and below personal injury amounts

• Exclusive Remedy:
  • Employee cannot sue employer for more compensation even with gross negligence
Goals of Treating the Injured Worker

GOALS

• Restore health and ability to work in a timely and cost effective manner

BARRIERS

• Injured Worker
• Employer
• Insurance Company
• Utilization Review
• Treaters
Association Between Compensation Status and Outcome After Surgery

A Meta-analysis

“Compensation status is associated with poor outcome after surgery. This effect is significant, clinically important, and consistent.”

“...the association between compensation and poor outcome to be stronger in studies of revision surgery. Analysis ...showed this association to be highly significant.”

- Ian Harris, FRACS(Orth); Jonathan Mulford, MB, BS; Michael Solomon, FRACS; James M. van Gelder, FRACS; Jane Young, JAMA.2005;293(13):1644-1652
Step by step approach

- **Before** the patient is seen:
  - Is this an accepted WC claim?
  - If patient presents and claims they were injured at work but no paper work has been filed:
    - **Patient** needs to go to employer to report claim
    - **Employer** needs to file DWC-1 Employee’s Claim for Workers’ Compensation Benefits
  - **YOU** need to file a first report of injury
DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS

2. EMPLOYER NAME

3. Address

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)

5. PATIENT NAME (first name, middle initial, last name)

6. Sex

7. Date of Birth

8. Address:

9. Telephone number

10. Occupation (Specific job title)

11. Social Security Number

12. Injured at:

13. Date and hour of injury or illness

14. Date last worked

15. Date and hour of first examination or treatment

16. Have you (or your office) previously treated patient?

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)

A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? Yes

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? Yes No If "yes", please explain.

23. TREATMENT RENDERED (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location
To get paid you need:
Authorization to treat patient
Authorization for treatment

• Next step: Complete RFA (Request for Authorization)
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
- [ ] Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
- [ ] Resubmission – Change in Material Facts
- [ ] 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.

<table>
<thead>
<tr>
<th>Diagnosis (Required)</th>
<th>ICD-Code (Required)</th>
<th>Service/Good Requested (Required)</th>
<th>CPT/HCPCS Code (if known)</th>
<th>Other Information: (Frequency, Duration, Quantity, etc.)</th>
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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)
Next step:

• If authorization received, proceed with treatment
• If no response or denied, call adjuster, start appeals process
• If it is an emergency, take care of the patient. It will get resolved in your favor.
Utilization Review

• RFA
• Peer to peer
• Appeals
• Maximus
PR2

State of California
Division of Workers’ Compensation

PRIMARY TREATING PHYSICIAN’S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is “Permanent and Stationary” (i.e., has reached maximum medical improvement) do not use this form. You may use DWC Form PR-3 or WC Form 81556.

☐ Periodic Report (required 45 days after last report)  ☐ Change in treatment plan  ☐ Discharged
☐ Change in work status  ☐ Need for referral or consultation  ☐ Info. requested by:
☐ Change in patient’s condition  ☐ Need for surgery or hospitalization  ☐ Other:

Patient:
Last          First          M.I.          Sex          D.O.B.
Address
City          State          Zip
Occupation
SS #          Phone ( )

Claims Administrator:
Name
Address
City          State          Zip
Phone ( )

Employer name
Employer Phone ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Diagnoses:
1. ___________________________ ICD-9 ___________
2. ___________________________ ICD-9 ___________
3. ___________________________ ICD-9 ___________

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CFT codes is encouraged. Have there been any changes in treatment plan? If so, why?)

Work Status: This patient has been instructed to:
☐ Remain off work until _______________
☐ Return to modified work on _______________ with the following limitations or restrictions
   (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):
☐ Return to full duty on _______________ with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp)  Date of exam: _______________

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: ____________________  Cal. Lic. #: ____________________
Executed at: ____________________  Date: _______________
Name: ____________________  Specialty: ____________________
Address: ____________________  Phone: ____________________
Next report due no later than _______________

DWC Form PR-2 (Rev./3/99) (Use additional pages, if necessary)
HIPPA and Worker’s Compensation

• Injured workers medical conditions and treatment need to be reported to the insurance company
• If the employer is self insured, then information goes to the employer
• If not self insured, then the insurance company is required to provide the information to the employer \textbf{NOT} the physician
• Less privacy protection
Patient has reached MMI: Maximum Medical Improvement
i.e. Their recovery has plateaued
PS: Permanent and Stationary. The case is ready to be rated.

Pointers:
- MMI/PS legal not medical terms
- Future medical care allowed
- Temporary disability payments: 2 year limitation in California
PR4/ Permanent and Stationary Report

- Summary of injury and treatment
- Work status
- Description of patient’s job
- Physical exam
- Subjective factors of disability
- Objective factors of disability
- Disability Rating
- Causation / apportionment
- Future Medical care
- Permanent Work Restrictions
Permanent Disability and Work Restrictions

- In California, prior to 2004 PD and Work restrictions linked
  Now, PD and work restrictions are separate

- California:
  - PD based on the AMA Guides to the Evaluation of Permanent Impairment 5th edition

- US Dept. Labor, Longshore and Jones Act:
Apportionment

• What is apportionment?

• Dictionary .com:
  • to distribute or allocate proportionally according to some rule of proportional distribution

• It is a legal term. How it is interpreted under CA workers compensation is subject to legal interpretation
  • Escobedo
  • Almaraz/Guzman
Escobedo

- WCAB ruling that distinguished between cause of injury and cause of disability.
- Apportionment does not apply to cause of injury
  - Under CA Workers Compensation Law, if the employment contributed even partially to the injury, treatment is covered under WC
Causation

• Is it medically probable that a contributing cause of the injury/illness was due to
  • Cumulative trauma from work?
  • A lighting up by the work injury of a previously non-disabling medical condition?
  • Why?
Escobedo

• WCAB ruling that distinguished between cause of injury and cause of disability

• **Apportionment applies to cause of disability**

• Benson and Brodie:

• Physician can only look at current disability and decide what directly caused the current disability:

  • Current industrial injury,
  • prior industrial injury,
  • nonindustrial injury
Almaraz Guzman II

• Decision by the California WC Appeals Board
• Addresses how the AMA Guides 5th edition, referenced by Labor Code 4660 and the 2005 Permanent Disability Rating Schedule can be rebutted
• If the AMA Guides rating is not appropriate, another section of the AMA guides may be used for the rating
Confusing Vocabulary: Causation Terms

• AOE: Arising Out of Employment  
• COE: Course of Employment
Confusing Vocabulary: Work Status

- **TTD**: Temporary Total Disability
- **TPD**: Temporary Partial Disability
Confusing Vocabulary: Disability Rating

• **P&S**: Permanent and Stationary
• **MMI**: Maximum Medical Improvement
• **QIW**: Qualified Injured Worker
  • Under prior WC system, described someone who was eligible for vocational training
• **Alamaraz/Guzman/Escobedo/Benson**:  
  • WBAC Court cases that set the rules for disability rating
Confusing Vocabulary:

- DWC: Department of Workers Compensation
- AME: Agreed Medical Exam
- QME: Qualified Medical Exam

IMR-Maximus: “independent medical review”
Why Treat Injured Workers?
References:

• http://www.dir.ca.gov/dwc
• Coa.org
• Doricage@gmail.com