Understanding Worker's Compensation

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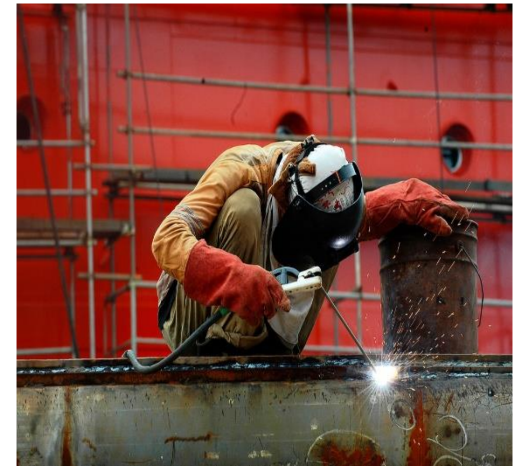
San Diego Hand Specialists

SAN DIEGO
HANDSPECIALISTS
CARE OF THE HAND & UPPER EXTREMITY
DORI CAGE, M.D.



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

8 CCR	California Code of Regulations, Title 8
ACOEM	American College of Occupational and Environmental Medicine
AD	administrative director
AMA	American Medical Association
AME	Agreed Medical Evaluator
AOE	arising out of employment
CF	conversion factor
CMS	Centers for Medicare and Medicaid Services
COE	course of employment
DEU	Disability Evaluation Unit
DIR	Division of Industrial Relations
DOI	date of injury
DOSH	Division of Occupational Safety and Health
DWC	Department of Workers' Compensation
EBM	evidence-based medicine
EOR	Explanation of Review
GAF	Global Assessment of Function
HCO	health care organization
IBR	independent bill review
IBRO	independent bill review organization
IMR	independent medical review
MEEAC	Medical Evidence Evaluation Advisory Committee
MPN	medical provider network
MPPR	Multiple Procedure Payment Reduction
MTUS	medical treatment utilization schedule
OMFS	Official Medical Fee Schedule
OSHA	Occupational Safety and Health Administration
PA	physician's assistant
P&S	Permanent and Stationary
PTP	primary treating physician
QME	Qualified Medical Examiner
RBRVS	Resource-Based Relative Value Scale
RVUs	Relative Value Units
SIBTF	Subsequent Injuries Benefits Trust Fund
SJDB	Supplemental Job Displacement Benefits
TD	Temporary Disability
TPD	Temporary Partial Disability
TTD	Temporary Total Disability
TPA	third-party administrator
UEBTF	Uninsured Employers Benefits Trust Fund
UR	utilization review
URO	utilization review organizations
WCAB	Workers' Compensation Appeals Board
WPI	Whole Person Impairment

Unique Vocabulary:

- DWC
- AOE
- COE
- TTD
- TPD
- MPN
- IMR-Maximus
- P&S
- MMI
- QIW
- Almaraz/Guzman
- List from DWC

Historic Compromise
Early 1900s

- 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

Permanent Disability Benefit Amounts: CA WC 2014

- Amputation of index finger $9,932.50 PIP joint
- Total loss of vision in one eye, $34,437.50 with normal vision (20/20) in other eye

Report Requirements

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

STATE OF CALIFORNIA

DOCTOR'S FIRST R

Within 5 days of your initial examination, for every o
insurance carrier or the insured employer. Failure to
suspected pesticide poisoning, send a copy of the repo
notify your local health officer by telephone within 24

1. **INSURER NAME AND ADDRESS**

2. **EMPLOYER NAME**

3. Address No. and Street

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

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

8. Address: No. and Street Ci

10. Occupation (Specific job title)

12. Injured at: No. and Street

13. Date and hour of injury of illness Mo. Day Yr.

15. Date and hour of first examination or treatment Mo. Day Yr.

Patient please complete this portion, if able to do so.
not affect his/her rights to workers' compensation under t

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSU**

18. **SUBJECTIVE COMPLAINTS** (Describe fully. U:

19. **OBJECTIVE FINDINGS** (Use reverse side if more
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
ICD-9 Code __

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 Date Mo. Day Yr. Estimated sta
admitted

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

Goals of Treating the Injured Worker

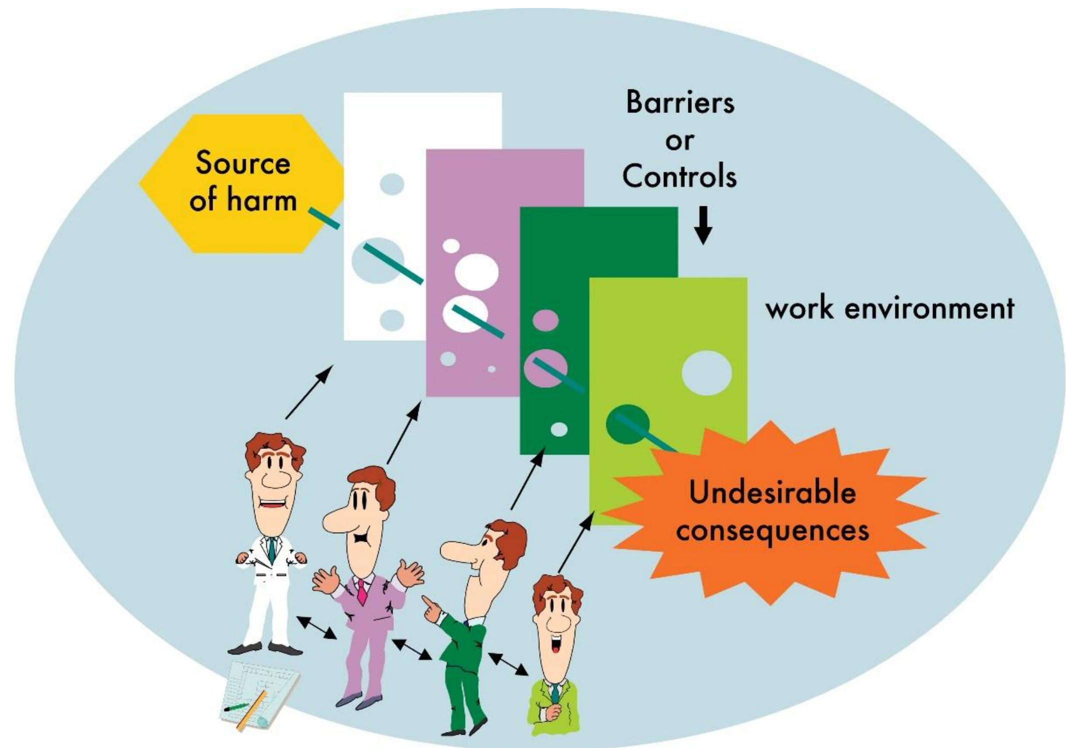
GOALS

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

Goals of Treating the Injured Worker

BARRIERS

- Injured Worker
- Employer
- Insurance Company
- Utilization Review
- Treaters
- Attorneys
- Societal: Entitlement



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 within 5 days

First Report of Injury

- https://www.dir.ca.gov/dosh/DoshReg/Form5020.pdf

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)

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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)

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

To get paid you need:
Authorization to treat patient
Authorization for treatment

- Next step: Complete RFA (Request for Authorization)

RFA: Request for Authorization

- https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf

PRINT CLEAR

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.

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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:

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Requesting Physician Signature: | Date:

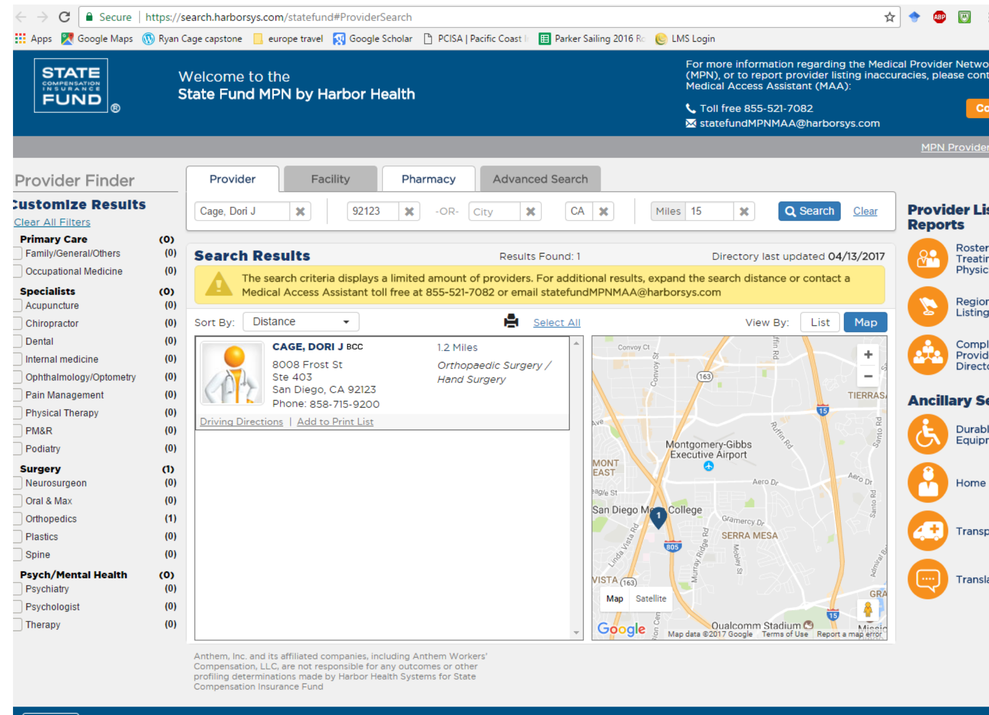
Claims Administrator/Utilization Review Organization (URO) Response

☐ 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)

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

Medical Provider Networks

- Limited provider pool
- Can treat outside of MPN if authorized
- MPN Process



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.

PR2 Progress note

- http://www.dir.ca.gov/t8/FormPR-2.pdf

State of California
Division of Workers' Compensation

Additional pages attached ☐

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 IMC 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 __________ Claim Number __________
Address __________ City __________ State _____ Zip __________
Phone (___) __________ FAX (___) __________

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 CPT 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 __________

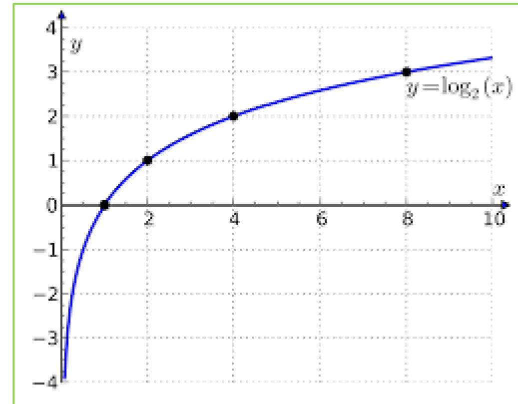
For Treatment Denials: Utilization Review

- RFA
- Peer to peer
- Appeals
- Maximus
- COA assistance

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 NOT the physician
- Less privacy protection

MMI/PS



- 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 independent of return to job of injury
- 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
- https://cdn2.hubspot.net/hubfs/697250/Forms/PR-4.pdf

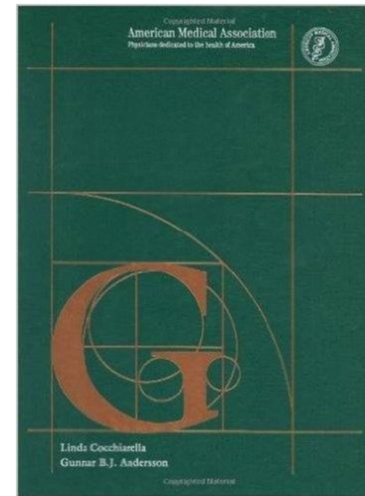
Permanent Disability and Work Restrictions

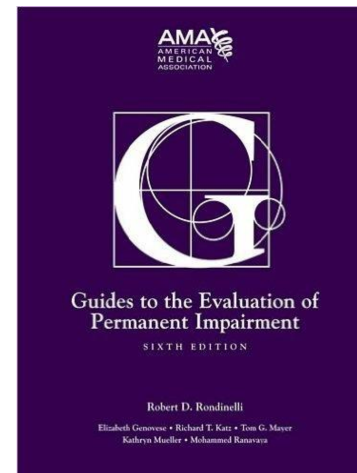
- In California, prior to 2004 PD and Work restrictions linked

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:
  - PD AMA Guides to the Evaluation of Permanent Impairment 6th edition

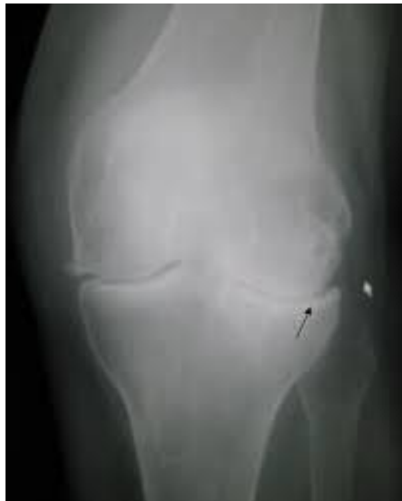




Causation

- 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?

  - 51% probability that work contributed to injury



Apportionment

- What is apportionment?
- Dictionary .com:
  - to distribute or allocate proportionally according to some rule of proportional distribution

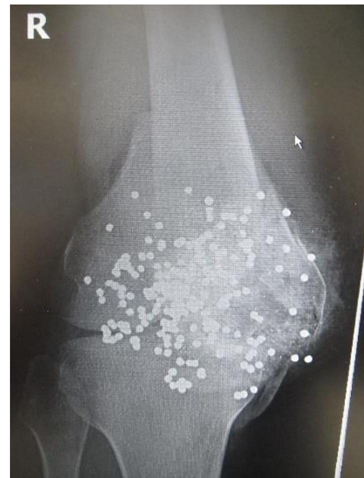
  - It is a legal term. How it is interpreted under CA workers compensation is subject to legal interpretation
  - Escobedo
  - Almaraz/Guzman

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

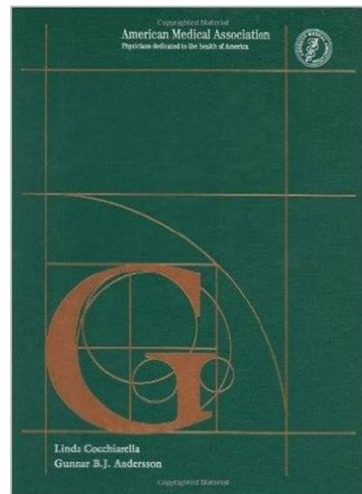
Escobedo

- 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



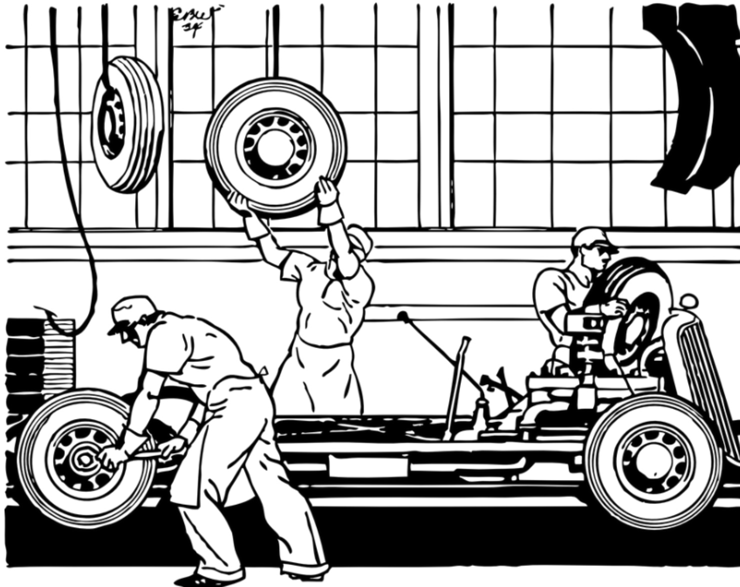
Almaraz Guzman II

- 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



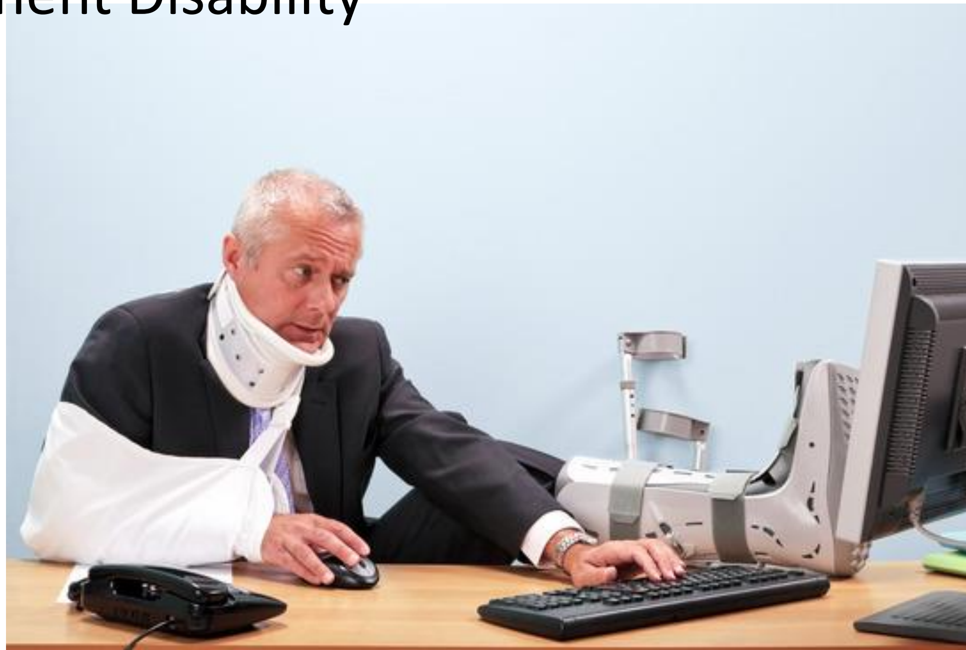
Confusing Vocabulary:
Causation Terms

- AOE: Arising Out of Employment
- COE: Course of Employment



Confusing Vocabulary:
Work Status

- TTD: Temporary Total Disability
- TPD: Temporary Partial Disability
- PD: Permanent 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:

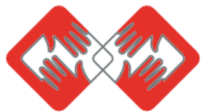
- DWC: Department of Workers Compensation
- AME: Agreed Medical Exam
- QME: Qualified Medical Exam

IMR-Maximus: “ independent medical review”

Why Treat Injured Workers?

References:

- http://www.dir.ca.gov/dwc
- Coa.org
- Doricage@gmail.com
- 2016 CA WC Guidebook http://www.dir.ca.gov/dwc/medicalunit/toc.pdf



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