



California Workers' Compensation Institute
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VIA E-MAIL to dwcrules@dir.ca.gov

September 3, 2014

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation, Legal Unit
Post Office Box 420603
San Francisco, CA 94142

**RE: Benefit Notices -- Title 8, California Code of Regulations,
§§9810–9815, Notice to Employees – §9881.1, Claim Form & NOPE – §10139**

Dear Ms. Gray:

This written testimony on proposed regulations regarding benefit notices, the Notice to Employees poster, the DWC1 Claim Form and Notice of Potential Eligibility (NOPE) is presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 71% of California's workers' compensation premium, and self-insured employers with \$46B of annual payroll (26% of the state's total annual self-insured payroll).

Insurer members of the Institute include ACE, AIG, Alaska National Insurance Company, AmTrust North America, Chubb Group, CNA, CompWest Insurance Company, Crum & Forster, Employers, Everest National Insurance Company, Fireman's Fund Insurance Company, The Hartford, ICW Group, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Group, Springfield Insurance Company, State Compensation Insurance Fund, State Farm Insurance Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members are Adventist Health, Agilent Technologies, Chevron Corporation, City and County of San Francisco, City of Santa Ana, City of Torrance, Contra Costa County Schools Insurance Group, Costco Wholesale, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway Enterprises Inc., Kaiser Permanente, Marriott International, Inc., Pacific Gas & Electric Company, Safeway, Inc., Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Shasta-Trinity Schools Insurance Group; Southern California Edison, Sutter Health, University of California, and The Walt Disney Company.

Introduction

The Institute's members appreciate the efforts made by the Division to revise the benefit notices in accordance with the new statutory reforms. The changes made by the Division following the Forum comments were very constructive. By creating a centralized electronic library, the Division can provide injured employees with more comprehensive and up-to-date information that applies to their circumstances. Enhancing the information available on the DWC's website will also make the notices less confusing for injured employees and provide access to more extensive information for those who need it.

The California workers' compensation system is extraordinarily complicated and for years the benefit notices provided to injured employees were inscrutable at best. Simplifying the notices has been extremely challenging. The proposed regulations contain the mandatory information that claims administrators must include in their benefit notices. The Institute's members commend the Division for crafting these notices and warnings at a readable 10th grade level.

The Institute recommends a few modifications to improve the Posting Notice and supports the revisions proposed for the claim form with the minor changes recommended. The Institute, however, recommends the Division modify the proposed version of the Notice of Potential Eligibility (NOPE) where so much unnecessary detail has been added that it fails to meet the statutory requirement in Labor Code section 5401(b) that: "The notice shall be easily understandable."

General Recommendations

Recommendation

State in these regulations that the DWC shall:

- 1) maintain the current compliant versions of notices on its website; and
- 2) archive and make accessible on its website prior versions with their effective dates.

Discussion

While it is important to move from the fact sheets to an electronic reference, because many claims administrators incorporate the information developed by the Division into their own notices, it is essential that whenever the DWC makes a change, claims administrators are notified and given a grace period to update their systems and to begin distributing the revised information. It is not unusual for disputes to arise regarding specific information that injured employees did or did not have at specific points in time. If the DWC website is to become a prime informational resource, then every revised version must be archived and accessible, and the effective date for using the information must be noted to establish the information in effect at any given point in time. We also urge the Division to be judicious in determining what changes are needed to the posting notice, as under Labor Code section 3551(a), required information on the posting notice must also be included in the time of hire pamphlet, so any substantive changes to the posting notice could have a ripple effect, impacting notices which were just updated and took effect July 1 of this year.

Recommendation Clarify in these regulations that claims administrators:

- 1) shall not be subject to audit penalties or adverse rulings for use of information obtained from the DWC website if the DWC has not notified the community that the information has been changed; and

- 2) shall be allowed a grace period of at least 120 days from the date when the DWC posts a Newsline announcing the changes in order to update their systems and begin distributing the revised information.

Discussion

In several proposed regulations, the DWC requires the claims administrator to refer the injured worker to the I&A Office and/or the DWC website for additional information. On multiple occasions, the DWC revised notice information on its website without notifying the community of the changes. The most recent example was on July 10 of this year, when the Division issued Newsline 2014-58 announcing it had posted a corrected version of the Spanish version of its Time of Hire pamphlet on its website because the version posted two weeks earlier did not include the required SB 863 changes. Yet when an additional error was found the next day and a second corrected version was posted on July 11, the Division did not notify the community.

Most workers' compensation policies renew on January 1 or July 1 of each year. To avoid having to supply duplicative notices to employers within the same policy period, the grace period should be timed to coincide with the most common policy effective dates (January 1 or July 1) to minimize costs and confusion. At least 120 days is necessary to allow sufficient time for programming, training, publishing, distribution, and posting.

Recommendation

Replace the mandatory term "will" in the 10-day QME process throughout these regulations to "may."

Discussion

If the employee fails to follow through with the QME panel process, administrators are not always required to complete it for them. Labor Code section 4062.1 does not mandate completion of the form.

Recommendation

Simplify the regulatory process by requiring the QME panel request form be provided *upon request* in all circumstances.

Discussion

As now proposed in these regulations, the QME panel request form must be provided with certain benefit letters and not with others, and at times (a denial of a single benefit), inclusion of the form is dependent on whether or not the denial is based on an opinion from the primary treating physician. In addition, the proposed regs now **ADD** a requirement that the form must be provided with a full denial letter, when currently it is only provided upon request. Not only do the proposed regulations fail to simplify the processing of the QME panel request form, they complicate it.

Recommendation

Adopt the Spanish translations of the benefit notices, Employee Poster, and the Claim Form with NOPE concurrently with the English versions.

Discussion

The Administrative Director is required to make Spanish translations of the notices, Employee Poster and Claim form with NOPE available to employers so that they may comply with

statutory notice requirements, including those in Labor Code sections 3550(d) and 5401(b). The Spanish translations are needed for Spanish-speaking employees at the same time as they are adopted for English-speaking employees.

Recommendation

Make the final regulations on the benefit notices, the Employee Poster, Claim Form and Notice of Potential Eligibility effective no fewer than 120 days after the filing with the Secretary of State, or on July 1, 2015, whichever is later.

Discussion

Most workers' compensation policies renew on January 1 or July 1 of each year. To avoid having to supply duplicative notices to employers within the same policy period, the effective date should be timed to coincide with the most common policy effective dates (January 1 or July 1) to minimize costs and confusion. At least 120 days is necessary to allow sufficient time for programming, training, publishing, distribution, and posting.

Recommended revisions to the proposed benefit notice regulations are indicated by highlighted **underscore** and **strikeout**. Comments and discussion are indented and identified by *italicized text*.

Benefit Notices

Section 9811(d) – Definitions

Recommendation

(d) "Dependent" means any person who may be or is claimed to be entitled to workers' compensation benefits as a result of an employee's death (including compensation which was accrued and unpaid to an injured employee before his or her death), **and includes the parent or legal guardian of a minor dependent child.**

Discussion

Neither the parent nor a guardian of a dependent minor child is a dependent.

Section 9812 -- Benefit Payment and Notice

Recommendation

~~If the claims administrator's determination is based on a medical report, a copy of the medical report(s) shall be provided with the notice, except for psychiatric reports that the psychiatrist has recommended not be provided to the employee.~~

The Institute recommends deleting this language from sections 9812(a)(3), 9812(d), 9812(e)(2), 9812(e)(3), and 9812(h) where this requirement is repeated.

Discussion

Labor Code section 4061(a)(1) requires only a notice of the worker's benefit status, i.e. a notice that there is no permanent impairment, or if permanent disability is payable, "the employer shall advise the employee of the amount determined payable and the basis on which the determination was made, whether there is need for future medical care, and whether an

indemnity payment will be deferred pursuant to paragraph (2) of subdivision (b) of section 4650.” The statute does not require the inclusion of supporting medical evidence with every benefit decision, therefore the Administrative Director does not have the authority to mandate it.

The language used in section 9812 requires the inclusion of a medical report even when the injured employee has already received the relevant report, the applicant's attorney has been served with it, or the worker has no interest in reviewing the report.

Section 9810(g) states:

The claims administrator shall provide copies to the employee, upon request, of all medical reports, relevant to any benefit notice issued, or which are not required to be provided along with a notice and have not yet been provided to the employee other than psychiatric reports which the physician has recommended not be provided to the employee.

Section 9810(g) requires only that a claims administrator make available to the employee **upon request** all copies of medical reports on which a benefit determination is based. The language of section 9810(g) is adequate to ensure that the injured employee receives relevant medical reports that they want to review. The option to provide these reports on request or to send them is, therefore, in line with the statutory authority and will prevent redundancy and needless processing in multiple benefit notices.

Section 9812(e)(3)

Recommendation – Section 9812(e)(3) -- First sentence

Notice That No Permanent Disability Exists. ~~In cases where the employee has sustained compensable lost time from work, if the claims administrator alleges that the injury has caused no permanent disability in a case where either the employee has received payment of temporary disability indemnity or the employee claims permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable. Where the employee has received payment of temporary disability indemnity, continued salary in lieu of temporary disability, or the employee claims permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable if the claims administrator alleges that the injury has caused no permanent disability.~~ This notice shall be sent at the same time as the last payment of temporary disability indemnity or within 14 days after the claims administrator determines that the injury has caused no permanent disability. ~~If the claims administrator's determination is based on a medical report, a copy of the medical report(s) shall be provided with the notice, except for psychiatric reports that the psychiatrist has recommended not be provided to the employee.~~

Discussion

Revise as recommended for clarity. See also comment on section 9812(a)(3), 9812(d), 9812(e)(2), 9812(e)(3), and 9812(h).

Notice to Employees Poster

Section 9881.1 -- Notice to Employees Poster.

Recommendation

Improve the poster by:

- adding to the description of the supplemental job displacement benefit that the injury must have caused permanent disability to the list of conditions necessary to qualify for the benefit
- re-organizing the material on the form to avoid unnecessary duplication or splitting of information that addresses the same subject, particularly on the subject of predesignation
- eliminating the unnecessary bolding in the body of a paragraph near the top of the second page

Discussion

- If the fact that injury must have caused permanent disability to the conditions necessary to qualify for the benefit is not added to the description of the supplemental job displacement benefit, an employee may be given the false impression that he or she will receive this benefit when injured unless his or her employer offered regular, modified, or alternative work.
- The material on the form can be re-organized to add clarity and avoid confusion caused by unnecessary duplication or splitting of information that addresses the same subject. This is especially so on the subject of predesignation, which is addressed in four different places on the form.
- The bolding in the body of a paragraph near the top of the second page is unnecessary. Bolding elsewhere in the form is used only for headings. An employee may get the wrong impression that the bolded portion is the most important portion of the form.

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Section 10139 – Workers' Compensation Claim Form (DWC 1)

Recommendation

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su **com-pañía** **compañía** de seguros, administrador de reclamos, o dependiente/representante de **recla-mos** **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

Discussion

The recommended changes correct inadvertent typographical errors.

Section 10139 – Notice of Potential Eligibility (NOPE)

Recommendation -- Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility (SEAL)

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. ~~Use the attached form to file a workers' compensation claim with your employer. You should read all of the information below.~~ Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. ~~If you lose time from work, the claims administrator who is responsible for handling your claim, must will notify you of your eligibility for benefits within 14 days whether your claim is accepted or whether additional investigation is needed.~~

~~Use the attached form to file a workers' compensation claim with your employer. To file a claim, e~~ Complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away ~~to avoid problems with your claim. In some cases,~~ because benefits ~~will may~~ not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. ~~If you mail the form to your employer, use first class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered.~~ Within one working day after ~~you file receiving~~ the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, ~~and~~ send one to the claims administrator ~~responsible for handling your claim and authorize initial medical treatment. Your employer is responsible for up to \$10,000 in medical costs until your claim is accepted or rejected.~~

Medical Care: Your claims administrator will pay ~~for~~ all reasonable and necessary medical care for your work injury or illness. Medical benefits ~~are subject to approval and~~ may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, ~~and~~ medicines, ~~equipment and travel costs.~~ Your claims administrator will pay the costs of ~~approved medical services~~ directly so you should never see a bill. ~~There are limits on chiropractic, physical therapy, and occupational therapy visits.~~

~~Medical Provider Networks (MPNs) and Health Care Organizations (HCOs) are groups of health care providers that provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an MPN or HCO. Contact your employer for more information. If your employer is using an MPN or HCO, in most cases you will be treated in the MPN or HCO unless you pre-designated your personal physician or medical group in writing prior to the injury. If you did pre-designate, you may be treated by your personal physician or medical group after you are injured.~~

~~If your employer is not using an MPN or HCO, and you did not pre-designate, in most cases, the claims administrator can choose the doctor who treats you for the first 30 days after which you may switch to a doctor of your choice if you need additional medical care.~~

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.

- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you pre-designated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.

- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you pre-designated your personal physician or a medical group.

- If your employer has not put up a poster describing your rights to workers' compensation, you may be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer shall the claims administrator must authorize up to \$10,000 in treatment for your injury, consistent with the applicable treating guidelines, for the alleged injury and shall until the claim is accepted or rejected. If the claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.

- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer provided health insurance).

- If you are not being treated in an MPN or HCO and did not pre-designate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see “Learn More About Workers’ Compensation,” below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator’s written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP’s opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can’t work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says you have permanent disability because you will not recover completely from your injury, and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 2013, 1/1/04, and your injury results in a permanent disability, and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher to pay payable for retraining and/or skill enhancement. This can include tuition at a state-approved school, books, tools or other resources to help you find a job. If you qualify, the claims administrator will pay the costs up to the maximum set by state law send information on what expenses are covered, the limits, documentation requirements, and deadlines.

Death Benefits: If the injury or illness causes death, payments may be made to a spouse and other relatives or household members individuals who were financially dependent on the deceased worker.

~~It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.~~

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or the claims administrator first to see if you can resolve it. If you have a dispute over a denial or modification of medical care, you can request an independent medical review using the form that will be sent by the claims administrator. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (800) 333-4606, or go to their website at www.edd.ca.gov.

~~It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If this type of discrimination is proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.~~

For Free Help and Information: You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems for free. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney: Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

Discussion -- NOPE

The recommended changes to the Notice of Potential Eligibility (NOPE) are intended to improve the flow, tone and accuracy of the notice and to delete unnecessary detail. The NOPE must accurately inform employees of workers' compensation benefits that are potentially available when they suffer a work injury without overwhelming or intimidating them with so much minutiae that the notice is perceived to be "fine print" and ignored. We have recommended changes that pare the proposed NOPE down to essential benefit information. Attached are "clean" versions of the proposed NOPE and the CWCI-recommended NOPE for ease of comparison. The proposed NOPE is almost twice the length of the CWCI-recommended NOPE. Also note that keeping the NOPE simple and understandable comports with the statutory mandates that "Insofar as practicable, the notice of potential eligibility for benefits required by this section and the claim form shall be a single document..." and "The notice shall be easily understandable and available in both English and Spanish." [LC §5401 (b)]. The current NOPE/DWC-1 (Rev. 6/10) accomplishes this by attaching the 1-page NOPE, printed on 2-sides in English and Spanish, as a single detachable cover sheet to the DWC-1 claim form. This format is compliant with the law and is convenient for the injured worker and the employer, and should be retained. But, barring the use of extremely small type or adding more pages to what is already a 5-page form (the NOPE plus the 4 required copies of the DWC-1) that will be extremely difficult if all of the additional detail that has been proposed is included.

Flow

The Institute-recommended NOPE consolidated and reorganized some information for efficiency and to improve comprehension. For example, information on getting medical treatment, including Information under the "Switching to a Different Doctor as Your PTP" is abbreviated and incorporated into the "Medical Care" section. Predesignation information is consolidated there as well. We moved the language of the "It is illegal for your employer" section into the "Resolving Problems or Disputes" section.

Tone

The information is best provided in a matter-of-fact way that will reassure and not alarm the injured employee at this stressful time of injury. Some parts of the proposed NOPE, including the following examples alarm rather than reassure.

The NOPE's purpose is to notify employees of potential benefits; not potential disputes. Warning all injured employees that although the law requires it, the claims administrator might not authorize treatment before a decision is made on the claim is hardly reassuring and rarely occurs. Suggesting the employee seek treatment for work injuries from a group health insurer is worrisome, confusing and inappropriate. The "Problems with Medical Care and Medical Reports" section also generates negative expectations that may suggest that injured employees need to adopt a confrontational attitude. None of this is necessary and none of it belongs in the NOPE. In the event a disagreement or dispute arises, the information on how to handle it will be sent to the injured employee, and the NOPE already provides information on where to get more information and assistance.

Accuracy

Some proposed content is inaccurate or misleading, including the following examples.

“If you lose time from work, the claims administrator who is responsible for handling your claim must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.” This statement is misleading at best. It may give the impression that the claims administrator may not notify an injured employee whether their claim was accepted or that investigation will only occur if time is lost from work. It is not an accurate statement even for all employees who have lost time from work because of a work injury, since employees who lose fewer than three days of work are usually not entitled to TD payments and are therefore not subject to the requirements of CCR 9812(a), where a 14-day requirement resides.

The last bullet under the proposed “The Primary Treating Physician (PTP)” section is incorrect. As a result of an SB 863 change to Labor Code section 4616.3(b), failure to post the “Notice to Employee” poster is no longer a basis for an employee to treat outside a Medical Provider Network with his or her personal physician unless it is shown that the failure to provide notice resulted in a denial of medical care.

Payment for permanent disability is no longer predicated on always being “limited in the work you can do.”

The proposed “Death Benefits” section does not accurately describe who is entitled to death benefit payments. Death benefit payments may be made to individuals who were financially dependent on the deceased worker.

Unnecessary detail

The notice must include information required by statute, including basic descriptions of workers’ compensation benefits, what to do and expect when filing a claim, and where to find additional information, but the Institute believes that the proposed version of the notice includes unnecessary detail. It need not include mechanical and technical details, details of processes or the law, or information that will be supplied later.

We recommend removing nonessential information such as mailing details, details on HCOs and all of the details added under “The Primary Treating Physician (PTP)” and “Switching to a Different Doctor as Your PTP” headings, none of which is necessary or required as a result of SB 863 changes. This much minutiae adds unnecessary verbiage, which dilutes the basic information that is required, makes the notice too long and complex, and runs counter to the statutory requirement in LC 5401(b) that “the notice shall be easily understandable.”

Thank you for considering our comments. Please contact us if further clarification is needed.

Sincerely,

Michael McClain
General Counsel

Brenda Ramirez
Claims & Medical Director

Robert Young
Communications Director

MMc:BR:BY
Attachments

cc: Destie Overpeck, DWC Acting Administrative Director
Christine Baker, DIR Director
James Robbins, DIR Counsel
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Return to Work Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members