Title 8. Industrial Relations
Division 1. Department of Industrial Relations
Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director - Administrative Rules

Article 8. Benefit Notices; Claims Administrator's Duties and Responsibilities; Claim Form and Notice of Potential Eligibility for Benefits; Regulatory Authority of the Administrative Director

§ 9812. Benefit Payment and Notice.

(a) Temporary Disability Notices. When an injury causes or is claimed to cause temporary disability:

(1) Notice of First Temporary Disability Indemnity Payment. The first time the claims administrator pays temporary disability indemnity, the claims administrator shall advise the employee of the amount of temporary disability indemnity due, how it was calculated, and the duration and schedule of indemnity payments. The notice shall be sent no later than the 14th day after the employer's date of knowledge of injury and disability.

(2) Notice of Delay in Any Temporary Disability Indemnity Payment. If the employee's entitlement to any period of temporary disability indemnity cannot be determined within 14 days after the date of knowledge of injury and disability, the claims administrator shall advise the employee within the 14-day period of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. If the claims administrator cannot make a determination by the date specified in a notice to the employee, the claims administrator shall send a subsequent delay notice to the employee, not later than the determination date specified in the previous delay notice, notifying the employee of the revised date by which the claims administrator now expects the determination to be made. A subsequent delay notice shall comply with all requirements for the contents of an original delay notice.

(A) Where the delay is related to a medical issue, and the claims administrator is requesting a comprehensive medical evaluation, and the employee is not represented by an attorney, the notice shall advise the employee of one of the following:

1. If the employee has already received a comprehensive medical evaluation, the employee may be asked to return to that physician for a new evaluation.

2. If no comprehensive medical evaluation has taken place, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must either:

a. contact the claims administrator within the applicable time limit prescribed in Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators, or

b. within the applicable time limit prescribed in Labor Code section 4062(a), download the form to request assignment of a panel of Qualified Medical Evaluators from the DWC website. (Note: the notice shall provide the employee with the url to enable the employee to download the applicable form.)

However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

(B) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions.

(3) Notice of Denial of Any Temporary Disability Indemnity Payment. If the claims administrator denies liability for the payment of any period for which an employee claims temporary disability indemnity, the notice shall advise the employee of the denial and the reasons for it. The notice shall be sent within 14 days after the determination to deny was made. 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.

(A) Where the denial is related to a medical issue and the employee is not represented by an attorney, the notice shall advise the employee of one of the following:

1. If the denial is based on a comprehensive medical evaluation, and the employee disputes the results of the evaluation, the employee may file an Application for Adjudication of Claim with the WCAB.

2. If the denial is based on the treating physician's evaluation of the employee's temporary disability status and the claims administrator agrees

with those findings, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must either:

a. contact the claims administrator within the applicable time limit prescribed in Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators, or

b. within the applicable time limit prescribed in Labor Code section 4062(a), download the form to request assignment of a panel of Qualified Medical Evaluators from the DWC website. (Note: the notice shall provide the employee with the url to enable the employee to download the applicable form.)

However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

3. If the denial is based on the treating physician's evaluation of the employee's temporary disability status and the claims administrator disagrees with those findings, the notice shall advise the employee that the claims administrator disputes the result of the evaluation. If the claims administrator's determination is based on a medical report, the notice shall be provided within the applicable time limit prescribed in Labor Code section 4062(a), notwithstanding the 14 days required by this subdivision. The notice shall advise the employee that the claims administrator disputes the results of the evaluation, and advise the employee that if he or she disagrees with the results of the evaluation, the employee must either:

a. contact the claims administrator within the applicable time limit prescribed in Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators, or

b. within the applicable time limit prescribed in Labor Code section 4062(a), download the form to request assignment of a panel of Qualified Medical Evaluators from the DWC website. (Note: the notice shall provide the employee with the url to enable the employee to download the applicable form.)

However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to

arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

(B) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions or need for clarification.

(b) Notice of Resumed Benefit Payments (TD, PD). If the payment of temporary disability indemnity or permanent disability indemnity is resumed after terminating any of these benefits, the claims administrator shall advise the employee of the amount of indemnity due and the duration and schedule of payments. Notice shall be sent within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

(c) Notice of Changed Benefit Rate, Payment Amount or Schedule (TD, PD). When the claims administrator changes the benefit rate, payment amount or benefit payment schedule for temporary disability indemnity or permanent disability indemnity, the claims administrator shall advise the employee, as applicable, of the amount of the new benefit rate and the reason the rate is being changed, or of the new benefit payment schedule. Notice shall be given before or at the same time as the new payment.

(d) Notice that Benefits Are Ending (TD, PD). At the same time as the last payment of temporary disability indemnity or permanent disability indemnity, the claims administrator shall advise the employee of the ending of indemnity payments and the reason, and shall make an accounting of all compensation paid to or on behalf of the employee in the species of benefit to which the notice refers, including the dates and amounts paid and any related penalties. If the decision to end payment of indemnity was made after the last payment, the claims administrator shall send the notice and accounting within 14 days after the last payment. 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.

(1) Where the determination is related to a medical issue and the employee is not represented by an attorney, the notice shall advise the employee of one of the following:

(A) If the termination of benefits is based on a comprehensive medical evaluation, and the employee disputes the results of the evaluation, the employee may file an Application for Adjudication of Claim with the WCAB.

(B) If the termination of benefits is based on the treating physician's evaluation of the employee's temporary or permanent disability status, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must either:

1. contact the claims administrator within the applicable time limit prescribed in Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators, or

2. within the applicable time limit prescribed in Labor Code section 4062(a), download the form to request assignment of a panel of Qualified Medical Evaluators from the DWC website. (Note: the notice shall provide the employee with the url to enable the employee to download the applicable form.)

However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible. If the claims administrator's determination is based on a medical report, the notice shall be provided within the applicable time limit prescribed in Labor Code section 4062(a), notwithstanding the 14 days required by this subdivision.

(2) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions.

(e) Permanent Disability Notices:

(1) Condition Not Permanent and Stationary, May Cause Permanent Disability -- Notice of Monitoring Until P&S Date. If the injury has resulted or may result in permanent disability but the employee's medical condition is not permanent and stationary, the claims administrator shall advise the employee at the same time as the last payment of temporary disability indemnity, that permanent disability indemnity is or may be payable but that the amount cannot be determined because the employee's medical condition has not yet reached a stationary status. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment or limitations and the need for future medical care. The notice shall advise the employee of the estimated date when a determination is likely to be made. If the claims administrator cannot make a determination of A) permanent and stationary status, B) the existence and extent of permanent impairment or limitations, and C) the need for future medical care by the date it specified in a monitoring notice to the employee, the claims administrator shall send a subsequent notice to the employee, not later than the determination date specified in the previous notice, notifying the employee of the date by which the

claims administrator now expects the determination to be made. The additional notice shall comply with all requirements of the original notice.

(2) Notice That Permanent Disability Exists. At the same time as the last payment of temporary disability or within 14 days after knowledge that the injury has caused permanent disability, whichever is later, the claims administrator shall inform the employee of the claims administrator's estimate of the amount of permanent disability indemnity payable, the basis for the estimate, whether there will be the need for future medical care, and whether an indemnity payment will be deferred pursuant to paragraph (2) of subdivision (b) of Labor Code section 4650. 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.

(A) Where the employee is not represented by an attorney:

1. If the determination is based on a comprehensive medical evaluation, the notice shall advise the employee that if he or she disputes the results of the evaluation, the employee may file an Application for Adjudication of Claim with the WCAB.

2. If the claims administrator's determination is based on an evaluation by a treating physician, the notice shall inform the employee whether or not the claims administrator is requesting a rating from the Disability Evaluation Unit. If the claims administrator is not requesting a rating from the Disability Evaluation Unit, the notice shall advise the employee that he or she may contact an Information and Assistance office to have the treating physician's evaluation reviewed and rated by the Disability Evaluation Unit.

3. If the claims administrator's determination is based on an evaluation by a treating physician, the notice shall advise the employee that if he or she disagrees with the results of the evaluation, the employee must either:

a. contact the claims administrator within the applicable time limit prescribed by Labor Code section 4062(a) to obtain the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators, or

b. within the applicable time limit prescribed in Labor Code section 4062(a), download the form to request assignment of a panel of Qualified Medical Evaluators from the DWC website. (Note: the notice shall provide

the employee with the url to enable the employee to download the applicable form.)

However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

(B) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions.

(3) 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. 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.

(A) Where the employee is not represented by an attorney, the notice shall advise the employee of one of the following:

1. If the determination is based on a comprehensive medical evaluation, the injured employee may file an Application for Adjudication of Claim with the WCAB.

2. If the claims administrator's determination is based on an evaluation by a treating physician, the notice shall inform the employee whether or not the claims administrator is requesting a rating from the Disability Evaluation Unit. If the claims administrator is not requesting a rating from the Disability Evaluation Unit, the notice shall advise the employee that he or she may contact an Information and Assistance office to have the treating physician's evaluation reviewed and rated by the Disability Evaluation Unit. The notice shall also advise the employee that if he or she disagrees with the results of the evaluation, the employee must either:

a. contact the claims administrator within the time limit prescribed by Labor Code section 4062(a) to obtain the form prescribed by the

DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators, or

b. within the applicable time limit prescribed in Labor Code section 4062(a), download the form to request assignment of a panel of Qualified Medical Evaluators from the DWC website. (Note: the notice shall provide the employee with the url to enable the employee to download the applicable form.)

However, if the employee has already received a comprehensive medical evaluation, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

(B) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions.

(4) Notice of Permanent Disability Indemnity Payment. At the same time as the first payment of permanent disability indemnity, the claims administrator shall advise the employee of the weekly permanent disability indemnity payment, how it was calculated, the duration and schedule of payments, and the claims administrator's reasonable estimate of permanent disability indemnity to be paid.

(f) Notices to Dependents in Death Cases. In a case of fatal injury which is or is claimed to be compensable under the workers' compensation laws of this state, or involving accrued compensation which was not paid to an injured employee before the employee's death, the claims administrator shall advise the dependent(s) of the status of any benefits to which they may be entitled or which they have claimed as a result of the employee's death. The claims administrator shall send each dependent a copy of all notices concerning benefits claimed by, or which may be payable to, that dependent, including notices sent to a different dependent if the benefits paid to the different dependent affect the amount payable to the other claimant. If the claims administrator discovers a new dependent after having sent a notice, the claims administrator shall send copies of each prior notice which concerned benefits to which the newly-discovered dependent might be entitled, to that dependent.

(1) Benefit Payment Schedule. If the claims administrator pays death benefits (including compensation which was accrued and unpaid to an employee before his or her death), the claims administrator shall advise each affected dependent of the amount of the death benefit payable to the dependent, how it was calculated, the duration and schedule of payments and other pertinent

information. Notice is required within 14 days after the claims administrator's date of knowledge both of the death and of the identity and address of the dependent.

(2) Notice of Changed Benefit Rate, Amount or Schedule or that Benefits are Ending. If the claims administrator changes the benefit rate, amount or payment schedule, or ends payment, of a death benefit to a dependent, the claims administrator shall advise the affected dependent of the change and the reason for it, or of the new payment schedule. A notice that benefits are ending shall include an accounting of all compensation paid to the claimant. A notice that payment is ending shall be sent at the same time as the last payment unless the decision to end payment was made after that payment; in that case it shall be sent within 14 days after the last payment. Other notices concerning changed payments shall be sent before or with the changed payment, but not later than 14 days after the last payment which was made before the change.

(3) Delay in Determining Benefits. If the claims administrator cannot determine entitlement to some or all death benefits, the claims administrator shall advise each affected dependent of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. Notice is required within 14 days after the claims administrator's date of knowledge of the death, the identity and address of the affected dependent, and the nature of the benefit claimed or which might be due. If the claims administrator cannot make a determination by the date it specified in a notice to the affected dependent(s), the claims administrator shall send a subsequent notice to the affected dependent(s), not later than the determination date specified in the previous notice, notifying the affected dependent(s) of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall include the employee's remedies and shall comply with all requirements for an original delay notice.

(4) Notices Denying Death Benefits. If the claims administrator denies liability for the payment of any or all death benefits, the claims administrator shall advise the affected dependent(s) of the denial and the reasons for it. The notice shall be sent within 14 days after the determination to deny was made.

(g) Notice of Delay in Determining All Liability. If the claims administrator cannot determine whether the employer has any liability for an injury, other than an injury causing death, within 14 days after the date of knowledge of injury, the claims administrator shall advise the employee within the 14-day period of the delay, the reasons for the delay, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. If the claims administrator

cannot make a determination by the date it specified in a notice to the employee, or if the reason for the delay has changed, the claims administrator shall send a subsequent notice to the employee, as soon as is reasonably practical, but in any event not later than the determination date specified in the previous notice. The notice shall inform the employee of the date by which the claims administrator now expects the determination to be made, and shall explain the reason for the additional delay. The additional delay notices shall comply with all requirements for an original delay notice.

(1) For injuries on or after January 1, 1990, if the claims administrator sends a notice of a delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that the claim is presumed to be compensable if not denied within 90 days from the filing of the claim form, and that this presumption can be rebutted only with evidence discovered after the 90-day period.

(2) For claims reported on or after April 19, 2004, regardless of the date of injury, if the claims administrator sends a notice of delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that Labor Code section 5402(c), provides that within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, for the alleged injury and shall continue to provide treatment until the date that liability is rejected. The notice shall advise the employee that the employer's liability for medical treatment under this Labor Code section is limited to ten thousand dollars ($10,000).

(3) For employees who are not represented by an attorney, where the delay is related to a medical issue, and the claims administrator is requesting a comprehensive medical evaluation the notice shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. The notice shall contain the following statement (with the phrase “10 days” in bold font as shown):

“Enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within 10 days to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within 10 days, we will have the right to submit the form. In addition, within 10 days after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform us of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.”

(4) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions.

(h) Provision of QME Panel Request Form. An unrepresented employee may object to a medical determination made by a treating physician by requesting the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. If an unrepresented employee requests the form, within ten business days of receipt of the objection, the claims administrator shall acknowledge receipt of the employee's objection and provide the employee with a copy of the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators.

The notice shall contain the following statement (with the phrase “10 days” in bold font as shown): “If you wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within 10 days to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within 10 days, we will have the right to submit the form. In addition, within 10 days after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.”

(i) Notice Denying Liability for All Compensation Benefits. If the claims administrator denies liability for the payment of all workers' compensation benefits for any claim except a claim for death benefits, including medical-only claims, the claims administrator shall advise the employee of the denial and the reasons for it.

The notice shall contain the following statement:

> Although your claim has been denied, if you believe that you still need medical treatment for your injury or illness, you have the right to obtain treatment outside the workers’ compensation system.
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> If you have your own health insurance, or are eligible to be treated by someone else’s health insurance, you can use that insurance to get medical care. You should advise your physician that you believe that your injury or illness is work related, so the health insurer can seek reimbursement from the claims administrator.
>
> If you do not have health insurance available, there are doctors, clinics, or hospitals that will treat you without immediate payment. You should advise any doctor, clinic, or hospital that agrees to treat you that you believe that your injury

or illness is work related so they can seek payment from the claims administrator through the workers' compensation system.

The notice shall be sent no later than 14 days after the determination to deny was made. 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.

(1) Where the employee is not represented by an attorney, and the determination is related to a medical issue, the notice shall advise the employee one of the following:

(A) If the determination is based on a comprehensive medical evaluation, and the employee disputes the results of the evaluation, the employee may file an Application for Adjudication of Claim with the WCAB.

(B) If the employee has not previously received a comprehensive medical evaluation for this claim, the notice shall be accompanied by the form prescribed by the DWC Medical Unit to request assignment of a panel of Qualified Medical Evaluators. The notice shall contain the following statement (with the phrase "10 days" in bold font as shown): "If you disagree with the decision to deny your claim and wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within 10 days to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within 10 days, we will have the right to submit the form. In addition, within 10 days after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform us of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment." However, if the employee has already received a comprehensive medical evaluation and he or she disagrees with the decision to deny the claim, the notice may instead advise the employee to contact the claims administrator to arrange for the employee to return to that same medical evaluator for a new evaluation if possible.

(2) If the employee is represented by an attorney, the notice shall instruct the employee to contact the attorney with any questions.

(3) For claims reported on or after April 19, 2004, if an employee has filed a completed claim form with the employer, the claims administrator shall advise the employee to immediately send for consideration of payment, all bills for medical

services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected, unless he or she has done so already. The claims administrator shall also advise the employee that the maximum payment for medical services that were provided consistent with the applicable treatment guidelines is $10,000.

(4) A copy of the Notice Denying Liability for All Compensation Benefits shall be served on all lien claimants, all claim for costs claimants, and all persons or entities that have been authorized by the claims administrator to furnish benefits, goods or services for which a lien or claim for costs may be filed under Labor Code sections 4903 through 4906, inclusive.

Note: Authority cited: Sections 59, 124, 133, 138.3, 138.4 and 5307.3, Labor Code. Reference: Sections 138.4, 4060, 4061(a), 4061(b), 4061(d), 4061(f), 4061(g), 4062.1, 4062.2, 4650(a)-(d), 4658(d), 4661.5, 4700, 4701, 4702, 4703, 4703.5, 4903-4906 and 5402, Labor Code.