CALIFORNIA WORKERS' COMPENSATION

A Manual for the Treating Physician

STATE COMPENSATION INSURANCE FUND

November 18, 1999

Dear Doctor:

Since the legislative reform of 1993, the primary treating physician assumes greater responsibility in the determination of an injured employee's eligibility for workers' compensation disability and vocational rehabilitation benefits. We recognize the increased demands this places on your practice given the complexity of the law and the specific reporting requirements when treating patients with occupational injuries or illnesses.

To assist you in understanding your expanded role within the Workers' Compensation system, State Compensation Insurance Fund has prepared this manual which has been revised/updated since the first edition published in 1996 (see especially Chapters 4, 5). In addition, State Fund has been accredited by the California Medical Association to provide 4 hours of Category I credits and by the Industrial Medical Council (IMC) for 6 hour QME credits when you return the successfully completed post-test and evaluation which accompany the manual.

After giving this publication a thoughtful review, we hope that you will appreciate two very important points:

1. Timely and informed decisions regarding diagnosis, treatment, and disability management insure the common goal: the return of injured employees to productive employment as efficiently and as safely as possible.

2. Communication between the physician, employee, employer, and claims administrator is critical to achieving this goal.

Our staff (including medical consultants) in each district office are available to assist you with any questions you may have.

Sincerely,

Gideon Letz, MD, M.P.H.
Medical Director

ACKNOWLEDGMENTS

The California Workers' Compensation System - A Manual for the Treating Physician is a publication of the State Compensation Insurance Fund.

The Manual is the core curriculum of the State Fund Continuing Medical Education Committee who give direction to the entire process.

The manual was originally written by William Lewis, Attorney in Charge, Santa Ana Legal Department; Phyllis Manska, Assistant Claims Manager, Santa Ana Claims Department; and Gideon Letz, MD, Medical Director, State Compensation Insurance Fund. New chapters in this edition were written by Henry Cuddihy, MD, District Office Medical Consultant at Riverside and San Bernardino; Jizell Albright MSN, RN, COHN-S and Gideon Letz, MD.

Jizell Albright, RN, was overall project coordinator for the Revised Edition. Nancy Edmonson, Medical Management Consultant on the Continuing Medical Education Committee, State Fund, did extensive review and editing for the revised edition. Other individuals contributing their comments and editorial assistance essential for the revision of the manual were, Brenda Ramirez, Claims Operations Consultant, and Phil Ganz, Vocational Rehabilitation Consultant, State Fund. Legal review was provided by Robert Daneri, Assistant Chief Counsel, Corporate Legal Department, State Fund.

Particular chapters were reviewed and editorial comment given by the following State Fund District Office Medical Community Liaisons: Sue Hensley, Santa Ana, Terri Fujii, Los Angeles. Two of the Medical Community Liaisons who worked on the project now have other positions within State Fund: Jerry Glass and Cynthia Kincey-Beatty, both of the Los Angeles District Office.

Expert review was performed by Alan MacKenzie, MD, of the California Industrial Medical Council, and the California Medical Association's Worker's Compensation Committee with particular thanks due Philipp Lippe, MD and Phillip Wagner, MD.

Penny Grief, State Compensation Insurance Fund, provided proofing and format implementation. Elaine West, State Compensation Insurance Fund, established the format style sheets. Cover design was provided by Sebastian Gee, State Compensation Insurance Fund. Special thanks are due State Fund Photo Records and Print Shop for reproduction and the TEP Unit in Insurance Services for assembly.

TABLE OF CONTENTS

APPENDICES

Second Edition
Revised, 1999

CHAPTER I

The California Workers' Compensation System At A Glance

Every year California's assembly lines, farms, manufacturing facilities, offices and other places of employment produce some sobering results: Thousands of employees become ill, are injured or killed in the course of their employment. Under California law, employers are liable for bearing the cost of any occupational illness or injury.

The California Workers' Compensation System is a legislatively mandated expression of social policy that employees in the State of California shall be provided, among other things, with compensation for work-related injury, illness or death regardless of the fault of any party.

Employers in California are legally required to provide workers' compensation insurance that serves two functions:

1. To ensure that injured employees receive prompt and complete medical treatment and wage replacement benefits for work-related injuries and illness; and

2. To enable the employer to assume a known and limited liability rather than risk the unknown and possibly disastrous liability from civil lawsuits.

The majority of current California workers' compensation law is codified in the California Insurance Code, California Labor Code (LC), and the Rules of Practice and Procedure of the Workers' Compensation Appeals Board, which appear in Title 8 of the California Code of Regulations (CCR). Appropriate citations from these sources appear throughout the text.

Benefits Available To The Injured Employee

The type of financial benefits provided to an injured employee depend on the severity of the injury or illness and are described below.

Medical Benefits

All injured employees are entitled to medical treatment for work-incurred injury or illness that includes professional services, hospital charges, nursing care, medications, and medical and surgical supplies that are "**reasonably required to cure or relieve from the effects of the injury**." [Labor Code §4600.] The services of a qualified interpreter may be authorized in some situations.

Temporary Disability Benefits

Temporary disability indemnity is a tax-free benefit paid to compensate an industrially injured or ill employee for the period in which he or she is undergoing medical treatment and is unable to work. Temporary disability payments are based on a seven-day week. Financial incentives or disincentives may influence motivation for return to work.

Temporary Total Disability Payments (TTD)

Temporary total disability payments are calculated using a formula based on two-thirds of the injured employee's average weekly earnings at the time of the injury. [LC §4653.] Temporary total disability payments are subject to maximum and minimum amounts. The current maximum is $490 a week. Injured employees earning $126 or less per week are paid their full weekly wages.

Temporary Partial Disability Payments (TPD)

When an injured employee has been released for modified duty that is only available at a reduced wage or reduced hours, then the injured employee may be eligible for Temporary Partial Disability benefits during the recovery period. The TPD payment is based on two-thirds of the actual weekly wage loss and is subject to the statutory maximum and minimum amounts. [LC §4657.]

Permanent Disability Benefits

The concept of permanent disability (PD) in the California Workers' Compensation System is based on permanent impairment due to a work-related injury and the "diminished ability of such injured employee to compete in an open labor market." [LC §4660(a).] PD may be total or partial.

"Diminished ability to compete in an open labor market" refers to the entire pool of jobs and occupations existing in the labor market, not just the particular job performed by the employee at the time of his or her injury.

The amount of permanent disability compensation can be determined after the employee has either reached maximum medical improvement (permanent and stationary) or his or her condition has been stationary for a reasonable period of time. However, there are some situations where the extent of permanent disability can be anticipated before maximum medical improvement, (e.g., an amputated limb).

The California Workers' Compensation system presumes, in the following four situations, that an injured employee will always be found to have Total Permanent Disability, (100 percent disability). [LC §4662.]

1. Where the work-related injury results in either the loss of both eyes or the sight of both eyes.

2. Where the work-related injury results in the loss of or use of both hands.

3. Where the work-related injury results in a "practically total paralysis."

4. Where the work-related injury to the brain results in "incurable imbecility or insanity" (cognitive dysfunction).

In all other cases, permanent total disability is determined in accordance with the physician's medical findings in the case.

Permanent partial disability means a permanent disability that will be rated at less than 100 percent, and is always determined in accordance with a physician's medical findings.

Vocational Rehabilitation Benefits

When an injured employee is unable to return to his or her usual and customary occupational duties as a result of permanent impairment, the injured employee may receive vocational rehabilitative services that are reasonably necessary to restore the individual to suitable gainful employment

In order for an injured employee to receive vocational rehabilitation benefits, he or she must be found to be a "Qualified Injured Worker" (QIW). Under current California law, a qualified injured worker is defined as an employee who meets both of the following requirements:

Medical Eligibility

The injured employee is medically eligible for vocational rehabilitation when "expected permanent disability as a result of the injury, whether or not combined with the effects of a prior injury or disability, if any, permanently precludes or is likely to preclude the employee from engaging in his or her usual occupation or the position in which he or she was engaged at the time of injury." [LC §4635(a)(1).] Physicians determine medical eligibility for vocational rehabilitation, but they do not determine QIW status. QIW status comes only after vocational feasibility has also been established. The determination of medical eligibility may be made prior to the injured employee's condition becoming permanent and stationary. Early identification of medical eligibility by the physician will expedite the vocational rehabilitation process.

Vocational Feasibility

The injured employee is vocationally feasible when he/she "can reasonably be expected to return to suitable gainful employment through the provision of vocational rehabilitation services." [LC §4635(a)(2).] This determination is made by a qualified rehabilitation representative (QRR).

When an injured employee is determined to be both medically eligible and vocationally feasible and chooses to participate in a vocational rehabilitation program, he/she will continue to receive temporary disability indemnity until his or her medical condition becomes permanent and stationary. At this point, further wage loss benefits depend on existence/extent of PD. For injuries on or after January 1, 1994, the injured employee may receive a maintenance allowance for a period not to exceed

52 weeks. Total vocational rehabilitation benefits cannot exceed $16,000. This includes the maintenance allowance, counseling fees, training and associated costs. [LC §139.5.]

Death Benefits:

When a work-related injury/illness causes the death of that injured employee, the employer is liable, in addition to any other benefits, for the following death related benefits: [LC §4700-4706.5.]

1. Reasonable burial expenses for the employee, not exceeding five thousand dollars for injuries occurring on or after January 1, 1991;

2. A statutory death benefit to be paid to the dependents of the deceased employee; and

3. In the event the deceased leaves no surviving persons who were financially dependent upon him or her at the time of death, the commuted value of the death benefit is payable to the Department of Industrial Relations.

CHAPTER II

Physician Responsibilities In The Workers' Compensation System

Unlike the typical doctor-patient relationship, the physician's role with injured employees is not limited to diagnosis and treatment. It may be the physician who is the first to raise the possibility that the employee's condition is work-related. Many physicians have not been specifically trained to recognize occupational injury or illness in the early stages, but a thorough history of the symptoms' relationship to work activities is the key.

One unique feature in treating an injured employee is the focus on functionality and return to work as the goal of therapy. This goal necessitates working as part of a team that includes the employer and claims administrator. The team may also include therapists, other healthcare providers, and a nurse case manager.

The responsibilities of the primary treating physician (PTP)* in the California Workers' Compensation System include:

- Determining medical causation, specifically the work relatedness of a condition;
- Providing diagnosis and treatment;
- Setting work restrictions and releasing for transitional work whenever appropriate;
- Communicating the patient's functional status to the employer and claims administrator;
- Determining when the patient's condition is *permanent and stationary*;
- Conducting the permanent disability evaluation, if necessary;
- Determining medical eligibility for vocational rehabilitation services;
- Managing and coordinating the care of the injured employee;
- Submitting timely, accurate written reports when required.
  [CRR §9785.]

*This term has specific legal implications for the WC system—See Chapter VI and glossary.

How the Primary Treating Physician is Defined

Under Title 8, California Code of Regulations, §9785(a)(1):

> The "**primary treating physician**" is the physician primarily responsible for managing the care of an injured employee who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter.

The Primary Treating Physician (PTP) renders opinions on all medical issues necessary to determine the employee's compensation benefits. (See Chapter VI, Physician Reporting.) The PTP is the physician selected by the employer or the employee (see below).

Secondary Treating Physicians

A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the injured employee, but is not primarily responsible for continuing management of the care of the injured employee. [CCR §9785(a)2.] The secondary physicians, physical therapists and other health care providers to whom the injured employee is referred shall report to the primary treating physician in the manner required by that physician. The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall incorporate, or comment upon, the opinions of the other physicians in the primary treating physician's report and shall submit all of the reports to the claims administrator. [CCR §9785(e)4.]

Selecting The Primary Treating Physician

The PTP is the physician selected by the employer or the employee by one of the following methods:

How A Primary Treating Physician Is Selected By The Employer

There are two ways in which an employer may select a PTP during the course of a work-related injury:

1. The employer may select the PTP for the first 30 days following notification of the injury, unless the injured employee has pre-designated a personal physician of record. [LC §4600.]

2. The employer can petition the Division of Workers' Compensation Administrative Director to change from an employee- to an employer-selected treating physician if there is medical evidence that the treatment is inappropriate, or there is failure to comply with reporting requirements for completeness and timeliness. [CCR §9786.] (See Chapter VI.) The employer must provide, in the petition, a panel of five physicians, or if requested by the employee, four physicians and one chiropractor from which the employee must select one. [LC §4603.]

How A Treating Physician Is Selected By An Employee

There are three ways in which an employee may select a PTP either before or during the treatment of a work-related injury/illness:

1. An employee may *predesignate* his or her personal physician to act as PTP in case of injury/illness by notifying the employer in writing. [LC §4600.]

2. An injured employee may request, at any time, a one-time change of physician. In this case the employer has 5 working days from date of request to provide such a change. [LC §4601.]

3. An employee may choose to be treated by a physician of his or her own choice within a reasonable geographic area any time after 30 days from the date that notice of the injury has been given to the employer. [LC §4600.]

Patient Referral

The injured employees may be referred for evaluation and treatment through various routes.

The Plant Physician

Occasionally, on-site medical staff will be the first to evaluate an injured employee. Even if this physician provides no treatment beyond the initial contact, the record of this encounter will be useful from the standpoint of description of the incident, work processes/duties, and baseline observations of functional capacity. Should the issue of compensability or work-relatedness be disputed, this initial report will be invaluable.

Employer Referral

Unless an employee *pre-designates* his/her own doctor, the employer has the legal authority to select the treating physician for an employee with a work-related injury/illness. The referral may be to occupational health clinics, urgent care centers, emergency rooms, or independent physicians. The referral may occur after an acute traumatic accident or because the employee complains to a supervisor of symptoms that are interfering with job performance.

Employee Self-Referral

The employee may present the treating physician with a complaint that he or she believes is work-related, without a referral from the employer. In this situation the issue of authorization for treatment is of major concern. The treatment rendered may be considered "self procured" and not compensable, unless specific authorization has been received from the employer/carrier. A simple telephone call to the employer will usually clarify the situation, and should be considered standard practice in the management of work injury/illness.

CHAPTER III

Clinical Management Of Work Injury/Illness

To achieve the best possible outcomes for patients with workers' compensation claims, the clinician needs understanding and sensitivity regarding a few key issues:

1. Treatment goals must focus on **functional restoration** and **return to work**.
2. Recovery is often dependent on **patient trust** of the doctor and **motivation** to participate in the treatment plan.
3. A "**team approach**" produces the most successful management of industrial disability. The players include the patient's employer, various ancillary providers, and the claims administrator.
4. Timely and effective **communication** between all parties is essential.
5. The clinician should be involved with **injury prevention**.

When these factors are ignored, rehabilitation of work-related injury/illness often becomes problematic. The clinician, patient and employer may all become frustrated when symptoms persist and return to work is delayed despite state-of-the-art diagnostic and treatment methods. The goal of this chapter is to provide a clinical approach and philosophy that will help minimize disability and optimize rehabilitation outcome.

As with any patient, the first order of business is to establish a **diagnosis**. This is often straightforward, clear-cut and completed at the first visit. In other cases it may involve observation over time and monitoring response to therapy (e.g., establishing a diagnosis of non-specific mechanical low back pain or upper extremity repetitive strain injury).

Once a working diagnosis is established, the physician usually can make a reasoned judgment regarding **work-relatedness**. This is essential since it determines who will be the **payor**. The workers' compensation system demands a "Yes" or a "No" determination, even when there is medical uncertainty. This can be a source of frustration for the inexperienced clinician who is accustomed to the scientific basis for clinical decision-making.

In the workers' compensation system, a determination that a condition is *probably* ("more likely than not") related to the alleged mechanism of injury or illness is sufficient to establish causation. Statements indicating that a condition is "possibly" related or that a condition "may be" related are inadequate to establish compensability and will generally result in further inquiries by the claims administrator.

It should be noted that there is nothing wrong with the physician changing an opinion after more information becomes available (e.g., more complete history, results of diagnostic

testing). If work-relatedness cannot be determined immediately but eventually causation is determined to be non-industrial, the cost for the initial evaluation is generally considered compensable under workers' compensation. Further medical care, however, will not be the employer's responsibility.

Treatment Goals

The management of work-related injuries must emphasize restoration of function and return to the workplace rather than alleviation of symptoms as the primary treatment objective. Treatment of workers' compensation patients will be fraught with problems if this principle is not appreciated. There are at least three reasons for this:

1. The longer an employee is away from the work site, the less likely the chance for a successful return to work.
2. Brief periods of rest may be necessary to initiate healing, but prolonged rest will cause deconditioning, which impedes further healing and may predispose the employee to chronic symptoms.
3. When return to work is delayed, psychological factors will interfere with recovery.

Once **functional restoration** and **return to work** are established as the **primary treatment objectives**, the injured employee can become an active participant in the rehabilitation process. For example, passive modalities that alleviate symptoms but do nothing to improve strength and flexibility are de-emphasized, while exercise therapy and transitional work are introduced as essential elements of the treatment plan as early as possible. Discussion and reinforcement of the treatment goals should occur at every visit to avoid misunderstanding and dependency, and to establish the patient as a partner in the rehabilitation process. A clear understanding of the treatment goals will facilitate successful outcomes and minimize the frustrations of delayed recovery.
(See Chapter IV, Disability Management/Early Return to Work.)

Early Return To Work

(See Chapter IV "Disability Management/Early Return to Work" for a complete discussion of early return to work.)

Returning the injured employee to gainful employment as expeditiously as possible is a major goal of the workers' compensation system, and the reasoned opinion of the treating physician is essential in this regard. When evaluating an injured employee's functional capacity, the treating physician must understand the **essential functions of the job** in order to assess the patient's readiness to return.

During the period of recovery, the treating physician must work with the employer to identify possible transitional work tasks that would facilitate the employee's rehabilitation. Consideration also should be given to work alternatives, job accommodation, or reassignment to another job.

Delayed Recovery

Another essential component of the successful management of workers' compensation cases is early identification of those patients at risk for *delayed recovery*. A review of the literature relating to work-related disability reveals a number of demographic and psycho-social variables that appear to be risk factors for prolonged disability. Although severity of injury is obviously a determinant of duration of disability, it is not relevant to a discussion of delayed recovery. Delayed recovery implies failure to regain functional capacity within the *expected time period*, given the nature of the injury or illness.

The type of injury is significant. For example, so-called "soft tissue" injuries are more likely to be problematic than fractures, dislocations, burns or lacerations. This is particularly true of spine related conditions (non-specific mechanical back and neck pain) because subjective complaints often occur without objective findings; there is no opportunity for a right-left comparison; and the source of pain is often obscure even after a comprehensive diagnostic work-up by experts in spine medicine.

Significant factors associated with delayed recovery include age, lack of education and poor general health. Job-related variables of importance include low wages, low seniority, heavy work, low job satisfaction, and poor relationship with supervisor. There has been significant research in this area but there are no adequately-validated, predictive tools available to date.

The Motivation Factor

Most risk factors for delayed recovery are associated with the level of motivation to return to work. Experienced vocational rehabilitation professionals usually can recall at least one example of phenomenal recovery of function following severe trauma. These individuals have the will to recover and refuse to accept disability, despite extensive injury.

At the opposite end of the spectrum are those individuals who present with persistent complaints of pain and other subjective symptoms with little or no objective findings; (i.e., they are functionally disabled without evidence of

physiologic impairment). The importance of motivation cannot be overstated and the physician must consciously assess patient motivation and attempt specific psychotherapeutic interventions when appropriate. The earlier the physician can identify patients at increased risk for delayed recovery and chronic disability, the greater chance there is of arresting the process and returning them to a productive lifestyle.

Secondary Gain

It has been assumed that disability behavior is learned because the same impairment produces very different behavior in different individuals. There are a number of psychological influences that reinforce the disabled role and counteract the desire to recover. The term "secondary gain" has been used to describe the factors that contribute to the maintenance of symptoms and inhibition of work performance. In essence, they create an advantage to persistent disability behavior. Secondary gain is distinct from malingering in that it involves unconscious phenomena that go beyond monetary support. Three types of secondary gain have been identified:

- Sympathy, attention and support;
- Being excused from responsibility, obligation or challenge; and
- Influence over important people by virtue of their acceptance that the individual is sick.

Additionally, the feeling of "victimization" (i.e., of having suffered an injustice, of being owed something by society) is often associated with secondary gain for workers' compensation patients.

The current workers' compensation system may foster illness behavior in a number of ways:

- The provision of tax free income, although usually less than full wages, may not constitute a financial hardship on employees earning near the minimum wage.
- Current laws are designed to provide compensation for being disabled, which may make a full effort toward rehabilitation difficult.
- Disputed cases typically are prolonged for more than a year. During this time, the individual avoids work because he or she feels it would adversely affect the claim. Also, litigation can prolong symptoms by creating unrealistic expectations of a large financial reward. Patients may recover quickly when their claim is settled.
- Often individuals are evaluated by multiple physicians and subjected to extensive diagnostic testing. This reinforces the perception that the patient may have a serious medical condition.

The treating physician can play a key role in the prevention of delayed recovery. When the disabled employee has persistent symptoms, the temptation is to respond by providing additional rest and time off from work. This common therapeutic approach actually creates a vicious cycle that will prolong recovery and perpetuate the sick role. **Transitional work is the most effective approach for the prevention of chronic disability.** It should be considered at the first visit and be an integral part of the treatment plan. (See Chapter IV.)

Communication Is The Key

One of the unique features of occupational medicine is the need for the treating physician to function as part of a team. The players on this team include the injured employee, the employer, the physician and the claims administrator. Depending on the specifics of the case, other parties may be involved, including an occupational health nurse, physical therapist, vocational rehabilitation counselor or the patient's family physician.

Communication With The Injured Employee

Experienced clinicians are aware of the importance of trust in the doctor-patient relationship. For the industrial injury patient the establishment of this trust may be particularly challenging and can require special attention. This is especially true if the patient has been referred by the employer. In this situation, the patient may view the treating physician as the stereotypical "company doctor" whose allegiance is primarily to the employer.

This should never be the case, either ethically or as a matter of law. It is important to remember that professional ethical codes and civil court rulings require that the physician's primary allegiance be to the patient.

Ethical and legal obligations notwithstanding, the injured employee often may assume that the employer-designated physician is unable to make objective, unbiased decisions relating to such issues as return to work, and that cost containment considerations will compromise the quality of medical care. Effective communication and an appropriate "bedside manner" for the physician require an awareness of this potential mistrust. Open and frank discussion concerning the patient's attitude and feelings about work are essential. It is often appropriate to

discuss return-to-work goals before the diagnosis and treatment plan is established.

It should be noted that decision-making regarding return-to-work status can be fraught with pitfalls, especially for the "soft tissue" injuries that are so common in the industrial setting. These conditions often involve pain syndromes with minimal or no objective findings. It is important to listen carefully to the patient and correlate the subjective complaints with clinical findings and diagnostic studies. Decisions regarding functional status and work restrictions, however, must be the physician's. The decision must be based on sound medical judgment and should not be inappropriately swayed by the employer, the claims administrator, the attorney or the patient's wishes.

The challenge for the clinician managing work injuries is to maintain a focus on the patient's problems and to involve him or her as an active participant in the rehabilitation process. It is important to emphasize that the physician, the patient, the employer, and the claims administrator all share a common goal: effective rehabilitation and prevention of further injury.

Communicating With Injured (Ill Worker)

- Listen;
- Sit down;
- Explain;
- Hands on exam.

Communicating With the Employer

Communication with the employer is essential in every case for a number of reasons including the following:

1. The employer is either directly (self-insured) or indirectly (via a workers' compensation carrier) paying for the medical care and disability benefits.
2. The employer has information regarding the work process and physical demands of the job that are essential in making decisions regarding the ability to accommodate functional restrictions. Since the physician does not always have the opportunity to visit the work site, obtaining information from the employer as well as the patient may alert the physician to ongoing issues that need attention; e.g., personnel problems, lack of adequate health and safety training, or the existence of specific hazards that could be eliminated through workplace redesign.

3. The employer must be informed about the prognosis for recovery in order to effectively plan for modified duty assignments, temporary coverage or permanent replacement for the injured employee.

Optimally, the employer should be consulted as soon as possible after an injury regarding the potential for transitional work so that the injured employee can return to the work site without unecessary delay.

Communicating With the Insurance Carrier

As the variety of health insurance systems has expanded in recent years, communication between providers and payors has become increasingly complex. It is not uncommon for a primary care physician to belong to dozens of Preferred Provider Organizations (PPOs) and HMO's, each with unique authorization and reporting protocols. The typical medical office has at least one staff person to keep abreast of the resultant paperwork.

There are fundamental differences, however, between group health plans and workers' compensation in relation to the provision of medical care benefits. These differences affect the nature and frequency of your communication with the payor.

Group health is a contractual arrangement that may include arbitrary limits on the extent of treatment covered. Workers' compensation medical care, on the other hand, is a statutory benefit with no arbitrary limits on the frequency, duration or extent of services. A group health claims administrator simply determines whether a given bill for medical services falls within the contractual limits of the policy. Workers' compensation personnel, however, must determine that the medical services rendered are "reasonable and necessary" to "cure and relieve from the effects of an occupational injury," and if they are likely to produce the efficient recovery of function and return to work.

In the workers' compensation arena, claims administrators need more frequent contact with physicians because information regarding possible transitional work, job modification, return to work, and prognosis for permanent impairment is critical to the fair and efficient provision of disability payments.

This contact with the claims administrator can have real advantages for the physician by providing direct access to the person paying the bills, and allowing authorization for reimbursement of treatment without misunderstanding and resultant delays. It is important to remember that claims administrators have an incentive to assure prompt and effective medical treatment so that claims are resolved as quickly as possible, but there must be clear documentation from the physician about treatment goals and progress toward those goals. When the treatment plan involves unusual

procedures or more extensive treatment than is expected for the "average" patient, specific justification should be provided by the treating physician. (For a more complete discussion of this process, see Chapter V, Utilization Review.)

The Problem of Litigation

When the physician is oriented to the workers' compensation system, maintains effective relationships with injured employees, and is properly trained in the management of common industrial injuries, a significant decline in the litigation rate can be expected.

If the treating physician fails to recognize and address the psycho-social aspects of the recovery process, the injured employee is apt to feel neglected. The doctor then often becomes frustrated because the injured employee is not responding as anticipated. In the workers' compensation system, this is what often leads to litigation, which, in turn tends to perpetuate disability behavior.

There are a multitude of reasons why an injured employee will litigate his or her claim. Regardless of the issues in dispute, the litigation process may greatly reduce the chance of successful rehabilitation and the return of functional capacity. Litigation provides incentives to stay away from work, since the system provides permanent disability awards that are related in part to duration of disability. Attorneys are reimbursed based on a percentage of the permanent disability award, so the goals are shifted away from functional restoration and focused instead on the financial award or settlement.

Toxic Exposure Cases

In situations where work disability has resulted from exposure to toxic chemicals, special care must be taken in communicating with the patient. These individuals typically have many questions regarding the type of exposure and potential health effects, yet frequently there are significant data gaps in the exposure and effect information. Particular care is necessary so that the patients are reassured, when appropriate, without misleading them or withholding information.

CHAPTER IV

Disability Management/Early Return To Work

Physicians are trained in diagnosis and treatment but most receive no specific training on disability management. The American College of Occupational and Environmental Medicine (ACOEM) has recently published a concise review of the subject as an introductory chapter in their "Occupational Medicine Practice Guidelines." It is reproduced here with permission from the publisher:

The Cornerstone of Disability Management

Currently, in the United States and Canada, most workers who report a work-related health concern can return to regular, temporary, or modified duty immediately or within a short period. Occupational physicians and other health professionals can make an important contribution to the appropriate management of work-related symptoms, illnesses, or injuries by managing disability and time lost from work as well as medical care. Prompt return to work in a capacity matched by the worker's remaining abilities and needs for rest, treatment, and social support prevents deconditioning and disabling inactivity, reinforces self-esteem, reduces disability, and improves the therapeutic outcome in most individual cases and on an aggregate basis. Disability management conveys respect for the injured or ill employees and provides social support that hastens recovery. The occupational health clinician should remember that most adults derive a good deal of their self-image from their work role. Removing them from that role removes a pillar of their self-esteem, sense of person and place, and sense of well-being.

From a physical standpoint, inactivity leads rather quickly to muscle and joint achiness, pain, and stiffness that may become a vicious cycle of inactivity and worsening musculo-skeletal complaints. Within a matter of days, muscle mass, tendon strength, and bone mass begin to decline. Reversal of these changes often takes much longer than the inactivity that caused them, particularly in older workers. Even limited activity, which is often easier to accomplish at the worksite, can prevent or mitigate these changes. For this and other reasons, patients with zero days' absence from work have the best chance of recovery. Important aspects of accommodation of the worker include (in descending order) light or modified work, flexible schedules, and reduced hours.

Ill or injured workers can be temporarily placed in different jobs from their usual jobs (temporary duty), or their usual jobs can be temporarily modified to accommodate their limitations and remaining abilities (modified or temporary transitional work). Accommodation, with progressively fewer restrictions as healing occurs, generally has a greater chance of success; the highest success rates are achieved when workers return to a modification of their pre-injury job.

Essential Job Functions and Accommodation

The occupational health professional can be of great service to employers and employees by helping develop a temporary modified job for ill or injured employees. The process of returning workers with health concerns, illnesses, or injuries to their job involves:

- *Determination of job demands and essential job functions;*
- *Carefully characterizing what the worker can do (depending on the job) in terms of motions, repetitions, force or load, rest, stretch or exercise breaks, use of machinery, exposure to climatic changes or extremes, use of protective equipment, and hours of work;*
- *Matching the two to determine how the worker's current job should be modified to avoid exacerbation and enhance recovery through increasing activity;*
- *Finding a temporary assignment for the worker if the job cannot be modified without undue economic hardship or danger to the worker or others;*
- *Changing the modifications as the worker increases his or her functional level.*

The clinician should remember that while impairment is defined as an anatomic change or reduction in physiologic or psychological function (WHO, 1979), impairment may or may not result in disability. Accommodation based on essential job function matched to worker ability can prevent an impairment from causing disability. The occupational health professional can identify accommodations that can be made, including periodic assistance by co-workers for infrequent but demanding tasks, workstation adjustment, including task alignment, load, seating and support, unbundling heavy collections of objects, and so on. Rest breaks are a reasonable accommodation as well. Readers are referred to guides for

accommodations under the Americans with Disabilities Act as a model for this process (remembering that disabilities covered by the ADA are permanent, while those discussed here are generally temporary).

While accommodation of an injured or ill worker may sound complicated, in most cases it is not. It is more productive than general restrictions that focus on estimated inabilities rather than specific abilities. Many employers are now installing proactive return-to-work programs based on this methodology. Programs based on descriptions of job tasks and requirements by groups of workers who do the job have perhaps the greatest accuracy and acceptance. Supervisors should also be involved in the generation of job descriptions.

Temporary transitional work should be framed as specifically as possible and emphasize what the worker can do. For workers with musculoskeletal conditions, as casts are removed, as other immobilization is reduced, or as healing or reconditioning progresses, updated reports describing current physical or mental conditions and increased abilities should be submitted. Engineering changes can also be made to accommodate specific impairments; in many cases, these changes also prevent recurrences. Examples include use of split keyboards for workers with hand or wrist complaints or workstations repositioning for workers with low back complaints.

Factors That Could Delay Return To Work

Occupational medicine providers should develop strategies to detect and address underlying causes of some complaints. Psychosocial factors that impede effective return to the workplace should be managed proactively. It is essential that these risks for delay in return to function are identified early. Worksite barriers or hindrances to return to work should also be addressed by occupational medicine providers.

A. Patient Factors

If the clinician has uncovered clues to personal or job-related factors that could delay the worker's return to work or recovery, an immediate evaluation of the worker by a behavioral health professional, framed as an evaluation of work potential, may be quite helpful. These factors may include substance abuse, family disorders, work conflict (especially with supervisors), low task enjoyment, financial problems, psychological problems (e.g., depression), and job

characteristics (low pay, low challenge, low control, monotony). Other possible obstacles to returning to work are the patient's lack of motivation, illness behavior (symptom exaggeration), inappropriate or ineffective treatment, a desire to use rehabilitation to change a job the worker dislikes, or the patient's having received legal advice to accept a lump sum instead of rehabilitation. The behavioral health professional should inquire about reasons the patient believes he or she is not able to return to work and cooperatively develop strategies to overcome the perceived barrier. There should also be discussion of how the patient has been functioning, what is going on in his or her life, and what plans the patient has for the future. In cases in which there are personal or psychosocial factors contributing to delayed recovery, psychological, psychiatric, or other behavioral health intervention is more appropriate than continuing medication, physical therapy, or surgery; continuing such treatment in the fact of treatment failure simply creates the expectation of disability.

B. Worksite Factors

Worksite factors preventing return to work should also be identified and addressed. These factors may include a failure to identify and provide modified work, rigid work rules, or an employer's or supervisor's unwillingness to accept a less than fully-recovered worker back, despite demonstrated improvement in cost effectiveness and recovery. The occupational health professional, others on the occupational health team, or the insurer may need to work with the employer to reduce these barriers.

Union membership may be a hindrance (or an enabler) for return to work. Some unions actively help members obtain modified work (for example, in Ontario), while others have attorneys available and encourage members to file workers' compensation claims and seek legal representation.

Return To Work As A First Step In Case Management

While return to modified- or temporary-duty work is an important first step in the functional improvement of workers with health concerns, it must be managed carefully. The factors contributing to absences from work are complex. Only some are medically related; others are personal, family, job- or worksite-related, or economic.

Absences from work for job-related health problems or concerns are often recurrent. While the success rate of return to work is about 85% when modified work is available, over a longer period of time, up to 50% of workers who file workers' compensation claims may not be working. This is primarily true of workers reporting back strain, and other strains and sprains. The return-to-work process is, therefore, the start of a case monitoring and management effort, which, for selected cases, should be long-term to achieve the greatest effect.

This ends the excerpt from the introductory chapter on disability management reprinted with permission from Occupational Medicine Practice Guidelines, ed. J. Harris, ACOEM, Part 1, Section 5: "Cornerstones of Disability Management," pp. 5-1 - 5-5. © OEM Press. References are located at the end of this chapter.

Early Return To Work and The Treating Physician

When managing work injury or illness, physicians need to think beyond relief of symptoms and focus on functional recovery. "Transitional Duty" is a valuable tool to facilitate rehabilitation because it allows return to productive work during the rehabilitation period. Keeping people at work helps to preserve self-esteem and prevents feelings of victimization and alienation which can cause depression and delayed recovery. Transitional duty is thus a key element of *secondary prevention,* i.e., the prevention of chronic disability. It should always be considered when the physician is formulating the initial treatment plan.

Transitional Work

Transitional work programs place injured employees who are not fully recovered, back to work in modified or alternative jobs that are suited to their functional restrictions. Employees are usually paid their regular wages while on modified duty, although assignments may involve changes in required tasks, hours and expectations. Several studies have documented that these programs result in earlier return to regular work than if the injured employee were at home with limited encouragement to progress.

Employees who return to the work site maintain a feeling of productivity despite their injury. This fosters a positive attitude by focusing attention on what they can do, rather than what they cannot. Maximizing activity consistent with the phase of recovery has both physiological and psychological benefits. For the vast majority of "soft tissue" injuries, immobilization beyond a few days is of questionable benefit. Even for the so-called repetitive motion or overuse syndromes, early activity should be encouraged.

Early return to work is a win-win process because there are clear benefits for the employer as well as the employee, including:

- less need for temporary employees to fill vacant positions left by injured employees;
- a decrease in disability payments as the employee's earnings increase;
- decreased Workers' Compensation litigation.

Early return-to-work programs convey a sense of concern that injured employees are valuable despite their temporary work restrictions, and that the employer is willing to accommodate the employee's physical and financial needs by providing modified jobs.

Reluctant Employers

Despite the established value of early return-to-work programs, some employers are simply unaware of potential benefits. Therefore, the physician can serve an important function as educator and facilitator.

If the employer refuses to accept the employee back to work until he or she is "one-hundred percent," return to work will be delayed until full function is restored. In such cases frequent appointments with the clinician to monitor progress with an emphasis on exercise in physical therapy and encouragement to remain active (e.g., walking, aerobics) keeping regular "work hours" (e.g., get up at normal time for work) are all important for the patient to prevent physical and psychological deconditioning. In extended temporary disability cases, employees can be encouraged to do volunteer work in their community to both feel productive and maintain social interactions.

Chapter IV is devoted to a fuller discussion of disability management and transitional duty including the Industrial Medical Council's policy and recommendations, and the American College of Occupational and Environmental Medicine (ACOEM) viewpoint on Disability Management.

Implementing transitional duty requires a cooperative effort between the doctor/therapist, the injured employee, the employer/supervisor and the claims administrator. Decisions about specific work restrictions need to be made without delay and reflect the injured/ill employee's functional capacity as he/she progresses toward full recovery or permanent-and-stationary status. Rational decisions require information about the employee's functional capacity at any point in time, the specific physical requirements of each job task, the ergonomic parameters of specific work stations, the employee's work habits and even information re: psychosocial issues, especially as they relate to motivation (e.g., relationship

with supervisor, attorney representation, co-existing financial or family problems).

Communication is the key to successful outcomes, and when it breaks down the outcome is invariably compromised. With larger employers, policies and procedures can be established in advance so that when an injury occurs, the information flows efficiently and without delay. With smaller employers, who may only rarely have a worker's compensation claim, communication is more of a challenge, but can be facilitated by the claims administrator, nurse case manager, or other insurance company staff; (e.g., return-to-work consultants). At a minimum, the physician or therapist should speak directly to the supervisor whenever there is a period of total temporary disability (TTD) or temporary work restrictions. The purpose of the call is both to obtain information about transitional duty opportunities and to explain the work restrictions and how transitional duty assignments are an integral part of the *treatment* and rehabilitation process.

The Job Description

As a first step in developing a rational return to work plan, the treating physician should review the injured employee's job description. If the employee does not bring the job description to the appointment, solicit it from the employer. The physician should expect to find the essential physical functions of the employee's job described in the following terms:

Balancing: Maintaining body equilibrium to prevent falling when walking, standing, crouching or running on narrow, slippery or erratically moving surfaces; or maintaining body equilibrium while performing gymnastic feats.

Bending: Forward motion of the upper body from the waist, or the head from the neck.

Carrying: Transporting an object, usually holding it in the hands or arms, or on the shoulder.

Climbing: Ascending or descending ladders, stairs, scaffolding, ramps, poles, ropes, etc., using the feet and legs and/or hands and arms.

Controls: Entails the use of one or both arms or hands and/or one or both feet or legs to move controls on machinery or equipment. Controls include but are not limited to: buttons, knobs, pedals, levers, and cranks.

Fine Manipulation: Picking, pinching, or otherwise working with the fingers primarily (rather than with the whole hand or arm as in handling).

Kneeling: Bending the legs at the knees to come to rest on the knee or knees.

Lifting: Raising or lowering an object from one level to another (includes inward pulling).

Power Grasping: Use of fingers, palm and wrist to hold and/or manipulate objects (hammers, saws, etc.). Object or tool cannot be easily pulled from the grasp.

Pulling: Exerting force upon an object so that the object moves toward the force (includes jerking).

Pushing: Exerting force upon an object so that the object moves away from the force (includes striking, slapping, kicking and treadle actions).
Reaching: Extending the hand(s) and arm(s) in any direction.
Simple Grasping: Use of the fingers primarily to hold and/or manipulate object (pencils, pens, etc.).
Sitting: Remaining in a seated position.
Squatting: Bending the body downward to rest the buttocks on the heels of the feet or the back of the legs.
Standing: Remaining on one's feet in an upright position at a work station without moving about.
Twisting: Movement of the body in a sideways motion either seated or standing.
Walking: Moving about on foot.

Use of these terms in writing work restrictions will facilitate the employer's understanding of the limitations required for the injured employee.

Reviewing the job description with the employee will provide clarification as he or she explains what they actually do. For example, the job title "Painter" can refer to someone who uses oil based paints on interior molding restoration in older buildings, as well as to one who works outdoors painting buildings or in a booth painting cars, both using an electric spray gun. Context is important in discerning health hazards and work restrictions.

Writing Return-To-Work Prescriptions

The goal of the work restrictions in the context of ERTW is to guide appropriate transitional work assignments. It is essential that the physician have a clear understanding of the nature of the work and working conditions to which the injured employee will be returning, and that the physician makes the restrictions in that context.

It is for the physician to determine:

The ***capacity*** for physical activity the injured employee can tolerate while continuing to heal;
The ***duration*** per day at that given capacity level of activity; and
The ***intervals*** of re-evaluation of capacity and duration.

Transitional duty assignments need to be regularly "fine-tuned" based on feedback from the injured employee and the employer with gradual progression toward regular work.

The occupational history taken as part of the injured employee's evaluation should include information on the injured employee's job tasks, how much time the different tasks take, and the material and physical exposures. Any information about how the employee spends the day at work will be valuable in the development of transitional duty assignments. The medical reports should reflect clear justification for all such assignments and/or work restrictions.

An understanding of the usual job tasks is necessary to formulate appropriate transitional duty assignments. Work restrictions on the other hand need to be written in terms of functional limitations, rather than referring specifically to the employee's current job. As an example, with a knee injury the injured employee may be restricted from climbing ladders, which may be a frequent requirement of his or her job. However, it is important to include other restricted activities such as standing or squatting or lifting heavy weight. When writing work restrictions, please refer to the terms listed above under ***The Job Description***. Employers are generally familiar with these terms through their common use in job descriptions.

When identifying parameters for modified or alternative duty the physician should be precise in describing the injured employee's specific restrictions. The statements "No heavy lifting" or "No repetitive bending/stooping" are too vague. The statement "No lifting over 40 pounds more than 10 times an hour", can be applied by the employer without ambiguity. Another example of a vague work restriction is: "Frequent breaks from computer work." A better description would be: "Three-minute stretch breaks from the computer every 30 minutes."

Note that there is a danger in writing restrictions specific to a job description. For example, a physician, in trying to protect a computer operator with carpal tunnel syndrome, writes "no keyboard use" and later finds that the employee was given another job task requiring awkward repetitive wrist movements.

Summary

The use of transitional duty is an effective strategy to facilitate rehabilitation after work injury and should be considered an essential element of every treatment plan. The Primary Treating Physician plays a key role by collaborating with the injured employee and the employer in identifying the correct level of transitional work. Carefully written work restrictions, revised as the healing progresses, optimizes outcomes.

Reprinted with permission from Occupational Medicine Practice Guidelines, ed. J. Harris, ACOEM, Part 1, Section 5: "Cornerstones of Disability Management," pp. 5-1 - 5-5. © OEM Press.

References

1. *Bruening LA, Beaulieu D. The return-to-work phase for the patient with cumulative trauma. In: Hunter JM, Schneider LH, Mackin EJ, et al. Rehabilitation of the Hand: Surgery and Therapy. St. Louis: Mosby, 1990. Pp 1192-6.*
2. *Butler RJ, Johnson WG, Baldwin ML. Managing work disability: why first return to work is not a measure of success. Ind Labor Rel Rev 1995;48:452-69.*
3. *Carmean G, et al. The Santa Barbara Project, Vols 1, 2. Santa Barbara: County of Santa Barbara.*
4. *Cornes P. The vocational rehabilitation index: a guide to accident victims' requirements for return to work assistance. Int J Disabil Studies 1990;12:32-6.*
5. *Dworkin RH, Handlin DS, Richlin DM, et al. Unraveling the effects of compensation, litigation and employment on treatment response in chronic pain. Pain 1985;49-59.*
6. *Field TF, Norton LP. ADA Resource Manual for Rehabilitation Consultants. Atlanta: Elliott and Fitzpatrick, 1992.*
7. *House JS, Landis KR, Umbertson D. Social relationships and health. Science 1988; 241:540-5.*
8. *Jokl P. The effect of the aging process on muscle and tendon injuries. In: Gordon SL, Gonzalea-Mestre X, Garrett WE Jr (eds), Sports and Exercise in Midlife Rosemont, IL: American Academy of Orthopedic Surgeons, 1993. Pp 515-29.*
9. *Nachemson A. Work for All: those with back pain as well. Clin Orthop 1983;179:77-85.*
10. *Rasmussen H, Minifie RL, Bruckman RZ, et al. Workers' Compensation Medical Management System. Seattle: Milliman and Robertson, 1996.*
11. *Reed, PO III (ed). The Medical Disability Advisor, 2nd Ed. Horsham, PA: LRP Publications, 1994.*
12. *Thompson D, Rempel D. Industrial engineering and ergonomics. In: LaDou J (ed), Occupational Health and Safety, 2nd Ed. Sitasca, IL: National Safety Council, 1994. Pp 163-86.*
13. *Theorell T, Harms-Ringdahl D, Ahlberg-Hulten G, et al. Psychosocial job factors and symptoms from the locomotor system: a multicausal analysis. Scand J Rehabil Med 1991; 23:165-73.*
14. *Vallfors B. Acute, subacute and chronic low back pain; clinical symptoms, absenteeism and working environment. Scand J Rehabil Med 1985;11 (suppl): 1-98.*
15. *Wesel SW, Feffer HL, Rothman RH. Industrial low back pain—a prospective evaluation of a standardized diagnostic and treatment protocol. Spine 1984; 9: 199-203.*
16. *World Health Organization. International Classification of Impairments, Disabilities and Handicaps. Geneva, 1980.*

CHAPTER V

Utilization Review

Background and History

During the past two decades, the cost of health care benefits nearly doubled every five years. In response, health insurers have introduced a variety of interventions designed to control costs. Most payors, both governmental and private, have extensive medical cost containment programs in place. Bill audits and pre-authorization requirements for hospitalization, specialist referral, surgery and other high-cost procedures are now commonplace.

The application of managed care interventions to workers' compensation is relatively recent. In the past, increased medical expenses were simply passed on from the insurance carrier to the employer in the form of higher premiums, but by the mid 1980's employers were convinced that escalating workers' compensation premiums were eroding their ability to compete with foreign companies. By 1990, medical costs had exceeded indemnity benefits in most states and the annual inflation rate for workers' compensation medical care was estimated at 13-15 percent, almost double that seen in health care generally.

During the past decade, the application of various managed care strategies has become commonplace in the workers' compensation system. Initially, there was emphasis on bill audits which were designed to retrospectively identify billing errors, excessive fees and inappropriate level of service billing. However, it was soon recognized that controlling the fee per unit of service did not result in cost savings because there was a compensatory increase in the frequency and duration of services which had no relation to improved outcomes. Fee schedule audits and preferred provider organizations based solely on fee discounts were therefore not effective as isolated mechanisms to control costs and improve patient outcomes.

Gradually, payors put more emphasis on *medical appropriateness* and initiated various forms of utilization review (UR). Traditionally used for in-patient admissions in group health, the same concept was applied to outpatient services in workers' compensation in an attempt to control frequency and duration of medical services. There are many variations on this general theme: Some programs target specific high-cost diagnostics tests such as MRI/CT, some target physical medicine services (physical therapy or chiropractic), others focus on diagnostic categories (soft tissue, spine, cumulative trauma or upper extremity)

Individual cases are often compared to consensus standards or treatment guidelines. To the extent that the escalating medical costs in the WC system are the result of inappropriate, unnecessary or inefficient use of medical services, UR programs can be expected to control costs and also improve functional outcome and return to work.

Utilization review was particularly appealing in California during the late 80's and early 90's when the problem of "workers' compensation mills", involving fraudulent collaboration between unscrupulous doctors and attorneys, reached epidemic proportions. UR was seen as a potentially effective strategy to counteract their abusive patterns of diagnostic testing and treatment. Many caring and knowledgeable physicians were impacted by the same UR strategies that were designed to control the greed of a few dishonest ones. Physicians were subjected to unreasonable scrutiny and "micromanagement" by some carriers and third party reviewers, which resulted in treatment delays for injured employees. Eventually there was enough political pressure from organized medicine and labor to establish specific regulations on Utilization Review. They were adopted by the Division of Workers' Compensation in 1996.

California's Utilization Review Regulations

California's UR regulations are designed to protect the injured employee and his/her physician from inappropriate denial of reimbursement or delay in authorization of medical services, while allowing payors to manage costs and improve patient outcomes by monitoring the frequency, duration and appropriateness of those services. These regulations are codified in Title 8, California Code of Regulations §9792.6. There are three key components of the regulations:

1. Credible, physician developed, medically-based criteria must be used in the UR process, and the criteria must be made available to affected parties on request.
2. Only physicians with like training and experience may recommend denial of authorization for medical treatment, or, recommend denial of reimbursement for medical services already provided.
3. Requests for authorization must receive a prompt response.

The Utilization Review Process

In most cases, the UR process begins with a request for authorization from the medical provider; i.e., the UR process is *prospective*, occurring *before* services are rendered. Occasionally, the UR process is *retrospective*, being linked to the bill review process and occurring after services have been performed. *Written* requests are now required and they do

protect the physician should a subsequent dispute occur; they can be submitted by FAX, e-mail or regular mail. Medical services specified in the Doctor's First Report or progress report constitute a "written request for authorization." The request for authorization must include specific identification of the patient and provider with a clear statement describing the proposed treatment. When cases involve surgical or unusual treatment or high-cost diagnostics, a specific statement explaining the medical necessity will save time and expedite the authorization process.

After receipt of a written request for authorization, the payor has seven working days to respond. The reply must include the name and phone number of a responsible medical contact person who will communicate one of three types of decisions:

- *AUTHORIZATION* for all or part of the requested services;
- *DELAY* in decision pending receipt of additional information from the provider requesting the treatment. Such a delay notification must specify what additional information is needed and when a decision can be expected after receipt of that information;
- *DENIAL* of all or part of the requested services.

Denial Decisions

Denial decisions are made on the basis of medical necessity. It must be based on *medically-based criteria* and the criteria used must be made available to the health care provider and the injured employee upon written request. The regulations provide assurance that any denial decision has been made by a peer reviewer with appropriate medical training and experience and that the reasons for the denial will be communicated in writing.

A premise of the UR regulations is that increased communication between providers and payors will minimize litigation. However, after a denial decision the provider can still perform the medical services and seek reimbursement on a lien basis. The Workers' Compensation Appeals Board (WCAB) has in fact interpreted *denial* under the UR process as identical with *notice of a disputed matter*. If the provider litigates the authorization decision by the payor, the payor will need the report of a Qualified Medical Examiner to present evidence at the WCAB. A denial may also be issued when additional information has been requested but has not been provided by the physician. In this case, the denial cannot be issued without documentation of a bona fide attempt to obtain the necessary information.

A written objection by the physician to a denial may initiate a medical-legal dispute that must be resolved in accordance with Labor Code §4062. This Code says that the physician is presumed to be correct in his/her clinical judgment unless there is a preponderance of medical evidence to the contrary.

Who Can Make Denial Decisions?

The Utilization Review regulations specify that a non-physician using medically-based criteria, can initially review the request for authorization. However, only a physician with an unrestricted license by his/her licensing board, who has education, training, expertise and experience that is pertinent for evaluating the specific clinical issue or service under review can deny authorization. [CCR §9792.6(c).]

What Is The Basis For A Decision?

Only medically-based criteria shall be used in the utilization review and decision-making process. [CCR §9792.6(c).] Upon request of the health care provider and/or injured employee, the criteria shall be made available. The criteria shall be:

- based on professionally recognized standards;
- developed using sound clinical principles and processes;
- developed with involvement of actively practicing physicians and be peer reviewed;
- evaluated at least annually and updated if necessary; and
- signed and dated by the physicians responsible for development.

The Treatment Guidelines developed by the California Industrial Medical Council (IMC), and the American College of Occupational and Environmental Medicine (ACOEM) are examples that meet all these criteria.

Any notice of denial or reduction of a bill that is made on the basis that the service was not reasonable and medically necessary and to which the health care provider has not previously agreed must include:

- the name of the peer-reviewer;
- the telephone number and hours of availability of the reviewer;
- the medical criteria upon which the denial or reduction was based.

The Use Of Treatment Guidelines

Treatment guidelines can be used in various ways–

- They can be *educational tools* for physicians in training or physicians who are inexperienced in managing a specific condition or complaint.

- They can be used as a triage tool for claims administrators to help them decide when a specific case should be referred for medical professional review.
- Review physicians can use treatment guidelines as a reference point as they compare the facts in a particular case with the "norm" as described by the guideline. Often the situation of a particular patient can be considered justification for treatment outside the usual as described in the guideline.
- The guidelines should never be used as the sole justification for denial of authorization. Denials should only be made when a peer reviewer has considered the specifics of the individual patient. Guidelines are developed to describe the expected, not the exceptional case.

The WCAB Retains Jurisdiction

The Workers' Compensation Appeals Board (WCAB) continues to make determinations in all disputes over medical treatment in individual cases.

Problem Areas

Several aspects of the UR process have been identified as being problematic during DWC public hearings and committee meetings:

- Failure of providers to request authorization, resulting in retrospective review by insurers;
- Non-payment of bills due to denial of the medical necessity of a billed service (retrospective review);
- Failure of the payor to respond to authorization requests resulting in delayed treatment;
- Failure of providers to supply medical justification;
- Difficulty in communicating the medical justification for specific procedures from medical professionals to claims administrators;
- Denials for authorization received without any clear medical basis or identified medical professional to contact.

The legislative intent of these regulations is clearly to improve communication between providers and payors. To the extent that they accomplish this goal, the problems outlined above hopefully can be resolved over time as the participants become more familiar with each others needs and methods of operation.

Summary

The California Utilization Review Standard [CCR §9792.6] is a code of conduct for both payors and health care providers. Use of these regulations assure that an up-to-date, reasoned medical opinion is behind reimbursement policies and decisions. This encourages physicians to also have reasoned medical opinion to support their treatment planning. The regulations represent a systematic change in focus from adversarial to communicative, from undefined criteria for treatment authorization to evidence-based medical decision making.

CHAPTER VI

Physician Reporting

Physician reports are essential for determining eligibility for workers' compensation (WC) benefits, so timeliness of these reports is of concern to everyone. This section is designed to provide a better understanding of the protocols and requirements of the California State Labor Code and State Fund's expectations regarding physician reporting. (See Appendix A for the relevant Labor Code sections.)

Role of the Primary Treating Physician

The Primary Treating Physician (PTP)* has the obligation to report on all medical issues necessary to determine eligibility for benefits. [LC §4061.5; CCR §9785.] The role of the PTP has been significantly expanded by recent workers' compensation reforms. The findings of the treating physician are presumed to be correct. [LC §4062.9.] The PTP must incorporate and comment on the findings of the other treating physicians, if any, and prepare a single report for the claims administrator, with secondary reports attached.

Reports: Introduction

There are three basic PTP Reports:

- Doctor's First Report of Occupational Injury or Illness (DFR);
- Primary Treating Physician's Progress Report;
- Primary Treating Physician's Permanent and Stationary Report, AKA Treating Physician's Determination of Medical Issues.

Appendix B contains sample forms which may be copied.

Both the DWC and the Industrial Medical Council (IMC) have published forms for the Permanent and Stationary (P&S) report but State Fund prefers the IMC Form 81556 entitled "Treating Physician's Determination of Medical Issues."

*The "PTP" is defined as the physician selected by the employee or the employer to perform specific responsibilities in the workers' compensation system. (see Chapter II). Other physicians who are consulted and/or provide treatment on the referral of the PTP, are designated as "secondary physicians" in the Regulations (CCR §9785).

One other report will be needed when the injured employee no longer has the ability to return to the same work as performed at the time of injury. This report is entitled the Report of Disability Status (RU90) and helps determine the injured employee's eligibility for vocational rehabilitation: See Chapter VIII: Vocational Rehabilitation: An Overview for the Physician.)

If a narrative report is used in lieu of any form, it must be clearly titled in bold-faced type and contain the same information and use the same subject heading in the same order as the standard forms. [CCR §9785, CCR §14003.]

Reports may be transmitted by mail, facsimile or any other manner satisfactory to the claims administrator.

Doctor's First Report of Occupational Illness or Injury

In California, each new primary treating physician must file a "Doctor's First Report" (DFR) **within five days after the initial examination** of a patient with an occupational injury or illness. This report must also be submitted by emergency and urgent care physicians.

This report should be completed with the same care and thoroughness as any entry into the patient's chart. In fact, many physicians organize their chart notes to coincide with the required format of the DFR. The form must be personally signed by the physician, and sent to the claims administrator.

This report serves multiple functions, which include:

- Notifying the employer/insurer that the physician has diagnosed a work-related condition;
- Notifying the employer/insurer of the planned course of treatment;
- Providing information regarding work status at the time of treatment and any projected period of disability;
- Assisting in the collection of statistical information concerning the industry-specific rates of work-related injuries/illnesses. (It is the responsibility of the claims administrator to forward a copy of the DFR to the Division of Labor Statistics and Research, California Department of Industrial Relations.)

How Much Information?

The report should include enough medical information for the claims administrator or reviewing physician to understand how the diagnosis was established, why it is work-related (especially when there is occupational illness or cumulative trauma), the planned course of treatment, and any necessary work restriction or temporary disability.

Key information includes:

- How, when, where the injury occurred;
- Specific diagnosis;
- Findings (including results of diagnostic testing);
- Treatment provided;
- Treatment plan;
- Work restrictions; and
- Duration of any anticipated disability.

Initial Narrative Reports

For complex or problematic cases with expected **prolonged disability**, an additional narrative report may be necessary. It is preferable for the narrative report to accompany the DFR. The report includes the identification features of DFR and provides a treatment plan that describes the expected course, scope, frequency and duration of the treatment, and an estimated date for return to regular work.

First Aid Cases

Injury/illness cases that require only a one-time evaluation and treatment, and neither time off work nor modified work; (e.g., minor scratches, cuts, burns, splinters, with no lost time beyond the date of injury) are defined as "first-aid" cases. For injury/illness after January 1, l994, the *employer* may choose to pay this one-time medical bill, and therefore does not need to give the employee a claim form or file an injury report with the insurer. By reimbursing directly their first aid cases, employers can minimize any negative impact these claims would have on their premium rates. **The physician is still required to file a Doctor's First Report on first aid cases**. [LC §6409.]

Pesticide Cases

Treatment for pesticide-related conditions requires that the physician file the DFR with the California State DWC. [CCR §14003.]

What To Do If...?

There are certain situations in which the decision to file a DFR becomes problematic. Some clarification of those instances may be useful:

1. An employer asks the physician not to file a Doctor's First Report

In cases of minor injuries (not classified as first aid treatments), employers may prefer to reimburse the physician directly without involvement of the insurer. This practice is illegal and can lead to prosecution if complicity with the practice is discovered. Further, the practice should be discouraged since a "minor" injury may become a complex problem; (e.g., wound infection), and the physician then becomes caught in reimbursement/liability disputes between the employer and insurance carrier.

2. The patient asks the physician not to file a Doctor's First Report

This may occur in time of high unemployment, when an employee is concerned about job security. This is particularly true if the injury is relatively minor and will not involve prolonged disability.

It is illegal for an employer to lay off an employee simply because he or she has a work-related injury or has filed a workers' compensation claim. [LC 132a(1).]

It is also illegal for a physician to avoid filing a DFR if he or she believes the injury truly is work-related. The physician should always explain the reporting requirements and necessity for contact with the employer at the beginning of the evaluation to avoid breach of confidentiality conflicts, or later misunderstandings between patient, physician and employer. [LC §6409.]

3. After initial evaluation, the physician concludes the illness/injury is not work-related

When the employer refers the patient or the patient has self-identified the complaints as work-related, and the physician diagnoses a non-industrial condition, the physician should still file a Doctor's First Report.

If the employee has group health coverage, the cost of this initial evaluation may be shifted to the non-industrial claims administrator. However, most workers' compensation insurers are willing to reimburse the provider for the initial evaluation if it was reasonably necessary to make a determination regarding work-relatedness.

PTP Progress Reports

Progress reports must be submitted by the Primary Treating Physician at reasonable intervals, but **at least every 45 days.** Legislative changes effective January 1, 1999, stipulate that secondary physicians or other workers' compensation health care providers must submit reports to the PTP. The PTP is required to incorporate and comment on the opinions of the secondary physicians in the body of the PTP report. The PTP attaches the Secondary Physician's Report to his/her report which is sent to the claims administrator.

Progress Reports using the PTP Progress Report Form (PR-2) should be promptly submitted by the PTP in the following situations: [CCR §9785.f.]

- The employee's condition
  - undergoes a previously unexpected significant change;
  - permits return to modified or regular work;
  - requires him or her to leave work or requires changes in work restrictions or modifications.
- There is a significant change in the treatment plan including, but not limited to:
  - a new need for hospitalization or surgery;
  - a new need for referral to or consultation by another physician;
  - a change in methods of treatment or in required physical medicine services; or
  - a need for rental or purchase of durable medical equipment or orthotic devices.
- The employer reasonably requests additional appropriate information.
- The employee is discharged with no residual impairment or loss of function. Simple discharge must be reported in the PTP Progress Report. This means that the injured employee has no residual impairment or loss of function and is returned to his/her pre-injury status with no need for further treatment.

Note: If the patients' recovery has been slow, if there have been long periods of Temporary Disability or transitional/modified duty, then a separate discharge report, may be appropriate.

Permanent And Stationary Report/Determination Of Medical Issues Report

The purpose of the permanent and stationary (P&S) report is to communicate to the claims administrator that the patient has achieved "maximal medical improvement" *but* is not back to pre-injury function. Assessment for P&S status should occur as soon as the injured employee has reached and maintained a medical plateau for a reasonable period of time. It is

important to understand that the P&S designation does not preclude the potential for further

medical improvement. Only a small percentage of injured employees will have permanent residual impairment and/or will require further medical treatment. With few exceptions, these individuals will reach this P&S status within six months of the date of injury.

Note: The "Report of Disability Status" which initiates eligibility for vocational rehabilitation is *not* to be confused with the "Permanent and Stationary Report" which defines the extent of permanent disability. A full discussion of the workers' compensation meaning of permanent disability and the clinical judgment required for reports is found in the next chapter, Chapter VII, Permanent Disability. For an expanded discussion on Vocational Rehabilitation eligibility, see Chapter VIII, Vocational Rehabilitation.

The purpose of the patient visit for determination of P&S status should be explained to the injured employee and time allowed for questions. The history should focus on current symptoms, a summary of the treatment rendered, the current level of function, apportionment, and the need for future medical treatment. Medical eligibility for vocational rehabilitation services will also be addressed. The physical examination should focus on the area of injury, with emphasis on objective findings such as range of motion and strength. Questions regarding administrative or legal issues should be referred to the insurance carrier or the injured employee's legal representative.

It is the responsibility of the PTP to write a P&S report. This may be submitted as a narrative that meets CCR §10606 requirements, or alternately on the DWC Permanent and Stationary Report or on the IMC "Physician's Determination of Medical Issues" Form PR3. The IMC form is preferred by State Fund. (See Appendix B.)

Supplemental or Special Reports

Occasionaly special or supplemental reports may be requested by the claims administrator, employer, or employee. Because the primary treating physician's opinions become evidence if there is litigation, and carry a presumption of correctness, it is essential to understand the purpose and objectives of the requested report and to follow an appropriate format. A timely, well written report allows the workers' compensation claim to be processed efficiently without compromising the injured employee's rights.

CHAPTER VII

Permanent Disability

Of those employees who are disabled by an on-the-job injury, most require only a short period of temporary disability. Occasionally, however, an injured/ill employee may have some degree of irreversible anatomic loss or physiologic dysfunction and, in some cases, will not be able to resume his/her original job. To ensure that these injured employees receive appropriate benefits from the workers' compensation system, it is important for the treating physician to understand certain concepts and terminology specific to the disability evaluation process.

Impairment and Disability

Impairment is any anatomic, physiologic, or psychologic loss or abnormality. It is assessed at the point when the patient is considered Permanent and Stationary (P/S) by the medical history, physical examination and appropriate testing. Some impairment can be easily measured objectively, such as loss of vision or hearing, decrease in extremity range of motion, or loss of grip strength. Less easily measured are subjective variables such as pain, emotional lability or fatigue.

Though impairment may produce **disability**, it is not synonymous. "Disability" is defined as reduced capacity to perform the activities of daily living or work. **Assessment of impairment must precede the administrative determination of disability.** The term "disability" is often used loosely and may cause confusion—e.g., the Labor Code states that physicians are required to do "disability evaluations." In fact, the physician's responsibility is to evaluate impairment, and the "Disability Rating Specialist" with the Division of Workers' Compensation (DWC) utilizes the doctor's description of impairment to determine the extent of compensable disability.

Disability is a legal term, defined differently depending upon the context. For example, the Social Security Administration has only two categories: disabled or not disabled, and does not consider partial disability. Even within the Workers' Compensation system there are significant variations from state to state. In the California Workers' Compensation system, the disability rating may range from partial to total (100%) representing an estimate of the employee's compromised ability to compete in the **open labor market** due to the impairment. [LC §4660.] The open labor market consists of all jobs or occupations, not just

the injured employee's usual occupation. Impairment results in disability to the extent that it compromises the employee's ability to secure or perform any job, not just his/her job at the time of injury.

Even though an injured employee returns to his/her pre-injury job, he/she may still have incurred a disability. An example of this is an employee who loses full use of the non-dominant left hand. The level of permanent disability would be substantial, yet if the usual occupation was that of a sales manager, for instance, there is a good chance that the employee could return to his/her former job without need for work restrictions. The level of permanent disability in this case would be based on the fact that the injured employee, without the use of one hand, is likely to be precluded from a large segment of the labor market. The level of compensation is based on this comparison rather than on any actual loss of employment or earnings due to the industrial injury.

It is generally true that disability cannot exist without impairment, nor impairment without disability. However, there may be an occasional rare case of impairment without a ratable disability or a disability without impairment. An example of impairment without disability would be a patient who has occasional minimal pain after recovery from a forearm fracture. Such residual would rate at 0% disability. As an example of disability without impairment, an individual who is a carrier of hepatitis but otherwise in good health would not have any impairment but could be considered disabled inasmuch as the person would be precluded from employment in certain jobs.

Impairment is thus a medical determination described in the physician's permanent disability evaluation report. This report is reviewed by the rating specialist in conjunction with the DWC's Schedule for Rating Permanent Disability in order to establish the permanent disability rating.

The following discussion provides more detailed information on how the physician's assessment of an injured employee's medical condition is used by the rating specialist.

Guidelines for Disability Evaluation - Factors of Disability

In general, the rating specialist requires information from the physician's report on each of the *Factors of Disability*:

- Objective factors;
- Subjective factors;
- Work restrictions;
- Loss of pre-injury capacity.

The report should be organized with distinct sections addressing each of these factors separately so that all essential information is included and easily identified by the rating specialist.

The rating specialist will look for internal consistency among the four categories of information. For example, a medical report that limits an injured employee to

sedentary work, but describes no objective findings on examination, will have little credibility. The goal of a disability report is to provide a complete picture of the individual's functional capacity.

Objective Factors

Objective factors (signs) can be measured, observed or demonstrated. They include physical findings such as range of motion, deep tendon reflexes, muscle strength, gait, and results of radiologic/laboratory examinations. Measurements should be clearly defined, comparing injured to uninjured, or injured to estimated normal. Avoid using terms such as "within normal limits" if a measurement can be given. Some elements of the physical examination are quite subjective, e.g., sensory testing, but these findings should be reported here since they are in theory reproducible by another examiner.

Depending on the nature of the impairment, a rating may be done directly from the physical findings. An example might be a measurable loss of motion of a major joint such as the knee or the elbow. The rating specialist can use the actual loss of function as compared to measurements of the corresponding uninjured joint or a normal range.

Subjective Factors

Subjective factors (symptoms) are those that cannot be directly measured or observed, such as pain, stiffness, paresthesia. It is important to note that this is the physician's assessment of residual symptoms and is based on the examination, the physician's experience with similar injuries and his/her expert medical opinion. It is not simply a catalog of an individual's complaints, as this might inaccurately inflate the disability rating if the complaints are not consistent with the physician's findings. Statements in this part of the report should be consistent with the nature of the injury and with the objective findings. Work restrictions based on subjective factors that are out of proportion to objective findings require specific explanation.

The recommended description of subjective disability should include the activity which produces disabling symptoms; the intensity, frequency and duration of symptoms; a description of the activities that are precluded and those that can be performed with the symptoms; and the means necessary for relief.

Pain Intensity and Frequency

It is important to remember that when the physician describes the pain intensity and frequency, it should not simply be a restatement of the patient's individual assessment but rather a statement of the physician's assessment based upon clinical judgment.

The following terms should be used in describing subjective factors. A rating specialist will presume that these pain descriptors denote relatively precise levels of restriction.

Minimal or mild pain is considered to be a nuisance and would not cause any kind of restriction. This level of pain would not result in a rating of permanent disability if taken by itself.

Slight pain is of a kind that is tolerable but, nevertheless, causes some degree of restriction in the activity which produces the pain.

Moderate pain is still tolerable, but causes significant restriction in the activity producing the pain.

Severe pain is presumed to preclude an activity completely.

Rating specialists also look for the following terms in the physician's report to estimate frequency and duration of pain:

Occasional means less than one fourth of the time.

Intermittent means one fourth to one half of the time.

Frequent means one half to three fourths of the time.

Constant means greater than three fourths of the time to 100%.

In actual practice it is very important that findings of subjective disability be precise as to **both severity and frequency** as the frequency will modify the severity. For example, a moderate level of pain that occurs only on an intermittent basis will be considered to be significantly *less* disabling than the same level of pain on a constant basis.

It is also necessary to relate the frequency and severity of pain to a given type of activity when pertinent in order to give an accurate picture of the injured employee's actual level of disability. A higher level of frequency might otherwise be assumed by the rating specialist if the physician were not to qualify a description of 'constant pain' when pain occurs only with a specific activity.

Examples of clear, precise statements are:

"The patient experiences intermittent, slight to moderate pain after prolonged sitting or standing."

"There is intermittent, slight pain which becomes constant moderate pain on repetitive bending."

An incomplete description is:

"The patient experiences some pain on a monthly basis."

The Weight of the Findings

In some cases subjective findings may stand alone as the sole basis for a final rating. Should subjective findings exist without supporting objective findings, a substantive explanation should be given. Findings for both the objective and subjective factors should be consistent with each other or clearly explained. See Appendix C.

Work Capacity Restrictions

Placing temporary restrictions on activity is often part of the treatment plan in an industrial injury. Most of the time these restrictions are gradually removed as recovery progresses and the injured employee is released from care without residual impairment. In cases where the severity of an injury will not permit release to unlimited activity, permanent restrictions should be clearly stated in the Permanent and Stationary report. Work capacity restrictions are the third element necessary for a permanent disability rating, together with objective and subjective findings.

Work restrictions are commonly used to describe residual disability in injuries to the spine, torso and lower extremities. Normally, a work restriction or set of restrictions will stand alone for purposes of disability rating. That is to say, if the work restriction rates higher than some combination of the objective and subjective findings, then the work restriction becomes the sole basis for the rating. The key point here is that the statement of permanent work restriction should represent prior consideration of the injured employee's level of pain and loss of physical function (the subjective and objective factors of disability). Another way to say this is that the work restriction is derived from symptoms and functional loss.

Restrictions Not Job-Specific

The restrictions may go beyond those specific to the job at the time of injury. As an example, with a knee injury the residual disability may prevent climbing ladders, which may be a frequent requirement of an injured employee's job and, therefore, a key restriction. It is important to determine if the permanent condition of the knee will also limit other activities, such as kneeling, squatting or lifting. All functional restrictions should be described, whether or not they are relevant to the job at time of injury.

It is important to think through the work restriction in this way because, unlike assessments of objective and subjective factors, consideration is given to what the injured employee can and cannot do relative to the "open labor market."

Loss of Pre-Injury Capacity

Once work restrictions have been clearly defined, loss of pre-injury capacity must be described. This requires knowledge of the employee's pre-injury functional capacity for both work and non-work activities. This estimate should be based on reasonable indicators such as occupational history, prior recreational activities, and/or comparisons of functional ability of the injured side with the uninjured side of the body. Guessing about the employee's pre-injury capacity is **not** sufficient. The report should state what the employee could do before as compared to after the injury. The loss of pre-injury capacity should be consistent with the other factors of disability. However, with sufficient information; (e.g., baseline functional testing) the loss of pre-injury capacity can be estimated more exactly.

The Industrial Medical Council (IMC) has published Practice Parameters for the Treatment of Common Industrial Injuries. [8CCR §70-76.] Included are Low Back Problems; Industrial Neck Injuries; Contact Dermatitis; Post-Traumatic Stress Disorder; Shoulder Problems; Knee Problems; and Problems of the Hand and Wrist. Guidelines for disability evaluation involving musculoskeletal (draft), cardiac, pulmonary, psychiatric and immunologic injuries can be obtained by writing to the IMC (see Resource List). For other guidelines, Packard Thurber's Evaluation of Industrial Disability may be referenced. (See Further Readings.)

CHAPTER VIII

Vocational Rehabilitation: An Overview For The Physician

When an injured employee cannot return to his/her usual occupation because of permanent impairment from an occupational injury or illness, he/she may be eligible for vocational rehabilitation (VR) benefits.

The goal of vocational rehabilitation is to enable an injured employee to return to *suitable gainful employment,* i.e., employment that can be reasonably attained, for which there is some demand in the labor market, and that is consistent with the employee's residual impairment, interests and aptitude. Vocational rehabilitation benefits include job training, maintenance allowance, and assistance with job placement.

Vocational rehabilitation benefits are available to a *Qualified Injured Worker* (QIW) who meets the following requirements: [LC §4635.]

Medical eligibility: The employee must be expected to be permanently disabled as the result of the injury. The disability, by itself or in combination with pre-existing disabilities, precludes return to the usual job or the job at the time of injury. The physician makes this determination.

Vocational Feasibility: When factors like age and prior disability are taken into account, the employee can be expected to find employment that is economically feasible after completing the vocational rehabilitation plan. A Vocational Evaluator (QRR) makes this determination.

In order to perform the function of determining **medical eligibility**, the physician must have a thorough understanding of the injured employee's job requirements. This information should be obtained on all patients with injuries involving lost time from work, because it is also essential for the development of a treatment plan that incorporates *temporary* job modification and early return to work. (See Chapters III and IV.)

Treating Physician's Report of Disability Status

When an injured employee has accrued 90 aggregate (not necessarily consecutive) calendar days of temporary disability, the claims administrator will ask the treating physician to complete and personally sign a *Report of Disability Status* (RU-90). The form will be

accompanied by a job description that has been completed jointly by the injured employee and the employer. The physician must comment on the individual's ability to return to regular or modified work, based on the history, examination, and review of the specific job duties. If it is not yet possible to determine whether the injured employee will be able to return to his/her position, the physician will be asked to provide updated reports every 60 days.

In this report the physician shall render an opinion concluding that the employee

- is released to return to his/her pre-injury occupation after additional treatment;
- will be released to pre-injury status;
- can return to the previous job with accommodation, or that the employee;
- is likely to be permanently precluded from returning to that job.

When the injured employee has returned to work, the physician might assume that VR eligibility is no longer an issue. It is still important to compare the employee's job description at the time of injury with his/her functional limitations, and then determine whether the employee is physically able to perform *all* of his/her former job duties. If all the essential duties cannot be performed, the employee and employer should be questioned regarding any accommodations or alternative work. If accommodations or alternative work are provided, the employee could still be considered *medically eligible* for vocational rehabilitation. However, by providing accommodations or alternative work, the employer may have fulfilled the obligation for providing vocational rehabilitation services.

When Should Medical Eligibility Be Determined?

Candidates for vocational rehabilitation should be identified as early as possible. The rehabilitation process can begin during medical treatment and *before* the individual is permanent and stationary. This reassures the injured employee of his/her potential to remain self-sufficient and prevents excessive focus on being "off work." It is <u>not</u> necessary to wait until the end of the 90-day period of disability to identify the injured employee as medically eligible for vocational rehabilitation. The physician can communicate this by a telephone call to the claims administrator or in a progress report at any time. The insurance carrier will then forward the RU-90 form to the physician.

The Vocational Rehabilitation Plan with the Greatest Probability of Success

QIW's who remain with their original employers with accommodations or, in permanently modified or alternative jobs have the best chance for long-term employment at wages most closely approximating their pre-injury wage. When plans involve extensive retraining for employment elsewhere, they are often not completed or result in jobs with significantly lower wages. Physicians can facilitate the more effective plans by communicating the need for job modifications as early as possible and by supporting the employer in the development of specific accommodations. Employers are not only incented by the workers' compensation system in California to support such VR plans, but also have some obligation under the Americans with Disabilities Act (ADA). Under ADA employers with fifteen or more employees are required to make "reasonable accommodations" for qualified individuals with a disability.

Note: ADA does not apply to temporary disabilities (i.e., injured workers who are not P&S) because most of these conditions resolve without residual disability.

Other Vocational Rehabilitation Plans

If permanent modified or alternative work is not available, a Qualified Rehabilitation Representative (QRR) will be assigned by the insurance carrier with agreement by the employee. The QRR and the employee will jointly develop an individualized plan. This may include on-the-job training, formal training, academic instruction, job placement or self-employment. Participation in any part of the vocational rehabilitation process by the employee is entirely voluntary.

Once a plan is developed, a job description may be submitted by the QRR to the physician to determine if this goal is compatible with the employee's residual disability. When this is requested, it is imperative that the physician be as thorough and precise as possible when assessing functional limitations due to residual impairment. Should the injured employee be unable to perform the functions outlined in the Vocational Rehabilitation (VR) plan or modified work assignment, a new plan will be necessary, increasing the costs and extending delays in returning the employee to suitable gainful employment.

In summary, the treating physician has a key role in the identification of employees who are candidates for vocational rehabilitation benefits and by reporting on a timely basis, will help avoid unnecessary disability periods and insure selection of an appropriate VR plan.

CHAPTER IX

Common Legal Issues

The vast majority of claims for Workers' Compensation benefits are handled expeditiously and without litigation. However, there are a number of individual claims that require the intervention of the Workers' Compensation Appeals Board (WCAB) to resolve differences in opinions between the injured employee, the employer and/or the insurance carrier. Such claims may involve the participation of the primary treating physician, depending on the nature of the disputes that arise.

A brief discussion of the seven most common issues that a primary treating physician (PTP) may be asked to discuss are described below.

Medical Causation

The California Labor Code states, in §3600, that in order for an employer to be held liable for the payment of compensation to an injured or ill employee, the condition must both *arise out of* and occur *in the course of* employment (AOE/COE).

The legal issue of whether an injury "arose out of" the injured employee's employment – that is, it was caused by the employment – is one that is commonly addressed by the primary treating physician.

Where Causation Is A Medical Question: Arising Out Of Employment (AOE)

"Causation" refers to whether the injury arose out of or was caused by some factor or factors related to employment. The reasoned medical opinion will be *presumed correct* when addressing issues of causation.

Cumulative trauma and occupational disease claims are often problematic in regard to causation, particularly those involving heart disease and psychiatric impairment.

In addition, when death of an injured employee is alleged to have been caused by the employment, such cases will involve purely medical causation issues. For example, if an employee is found dead at his or her place of employment and the death is attributable to a heart attack, the physician may be asked to comment on whether any factor in the decedent's employment precipitated the heart attack.

When Causation Is Not A Medical Question: In The Course of Employment (COE)

In a number of cases, the actual causal connection between the alleged injury and the employee's employment is not within the purview of the primary treating physician because "causation" is not a medical question, but rather a question of fact. For example, an injured employee who suffers a broken arm may claim that the injury occurred at work. The employer, however, has information that the employee may have broken the arm at home. In such a case, the final determination of "causation" must be decided by the Workers' Compensation Appeals Board, based on evidence presented by both the employer and injured employee.

Nature And Extent of Temporary Disability

Disputes may arise as to the period during which an injured employee is entitled to temporary disability benefits. As previously discussed, the primary treating physician is responsible for determining whether or not the injured employee may return to full or modified work while under medical treatment.

If the physician determines that an injured employee is not able to return to work for a period of time due to his/her industrial injury, he/she is considered temporarily totally disabled and entitled to TTD payments for that period.

If the injured employee is able to return to work in a modified capacity during the period of medical treatment, modified work is available, and he/she does in fact return to modified work, he/she may be entitled to *temporary partial* disability payments. This "wage loss" replacement equals 2/3 of the difference between the average weekly wage and the weekly earnings from the modified work schedule or assignment.

If the injured employee is able to return to his/her usual-and-customary work activities during the period of medical treatment, the employee will not be entitled to temporary disability payments.

Disputes are less likely if the physician is clear on the activity restrictions appropriate to the severity of the injury; the employer is prepared to accommodate the injured employee; and the employee understands the importance of progressive resumption of activity as part of the treatment plan.

Nature And Extent Of Permanent Disability

Disputes regarding the extent of permanent impairment and disability are perhaps the most frequently contested issue in the workers' compensation system.

As noted in Chapter I, a disability is considered permanent after the employee has reached maximum improvement or his/her condition has been stationary for a reasonable period of time.

If the injured employee is permanently disabled, the date on which an injured employee becomes **permanent and stationary** is of importance to both the injured employee and the employer. On this date, permanent disability benefits begin and the employee is no longer eligible for temporary disability payments.

Apportionment Of Current Disability To Previous Disability

The California Workers' Compensation system currently allows for apportionment of permanent disability in two situations: (1) when there has been a pre-existing disability prior to the work-related injury/illness; and/or (2) when the employment has aggravated a pre-existing condition.

Apportionment of the Current Disability to Pre-Existing Disability

An injured employee with an impairment that existed prior to a work-related injury and who is determined by the treating physician to have additional permanent impairment as a result of the injury is only entitled to compensation for the portion of permanent effects due to the *current* injury, and not to compensation that reflects a combination of both the prior disability and the current disability. [LC §4750.]

When such a situation occurs, it is up to the treating physician to determine the extent of the injured's total disability that is due to the work-related injury, as if such disability existed by itself.

The following is an example of the appropriate language:

"I currently find that Mr. Jones has permanent impairment of his back, resulting in a work restriction that limits him to light work. This work restriction is due to the combined effects of his pre-existing back injury, which occurred on March 17, 1994, as documented in the medical records, and which, absent his current injury, resulted in a work restriction of *no heavy lifting*."

A description of this type would entitle Mr. Jones to compensation for the **difference** between the pre-existing back injury that produced a work restriction of "no heavy lifting" (20% disability per Guidelines for Work Capacity) and the restriction of "light work only" (50% disability per Guidelines for Work Capacity), or 50% minus 20% = 30%.

Failure to "apportion" the permanent disability effects of the prior back injury would inaccurately result in a 50% permanent disability rating.

Apportionment Due To An Aggravation of a Pre-Existing Disease

In cases where employment causes aggravation of a disabling disease process that existed prior to a current compensable injury, the injured employee is entitled to compensation only for the portion of the disability due to the aggravation of such prior disease and which is reasonably attributed to the injury. [LC §4663.]

An example of appropriate apportionment language in such instance is:

"I currently find that Mr. Jones has a disability that restricts him to light work only. However, due to the natural progression of his pre-existing underlying arteriosclerotic heart disease, I find that absent Mr. Jones' current cardiac problem, he would have a work restriction that would limit him to no heavy work. Therefore, the degree of disability due to his current work-related injury is limited to the difference between a work restriction of no heavy work and his current restriction of light work only."

Need For Continuing Medical Treatment

The primary treating physician may be asked to comment on the need for continuing medical treatment, either before the injured employee is considered permanent and stationary or after he/she returns to work.

There are cases where the treating physician has discharged an injured employee from further care, and the injured employee subsequently seeks another physician who will indicate that the injured employee is unable to work and still in need of medical treatment. This necessitates an examination and concurrence by a Qualified Medical Evaluator before a new treating physician can be authorized as no other primary treating physician shall be identified unless and until the dispute is resolved. [CCR §9785(a)(b).] Clear, complete assessment and treatment by the initial physician can preclude unnecessary additional evaluations and inappropriate treatment.

Need For Future Medical Treatment

When the injured employee is found to be permanent and stationary from the effects of his or her industrial injury, the physician must comment on the need for and type of expected future medical care for the injury. Examples are treatment for anticipated flare-ups or possible surgery at a later time.

The need for future medical care should be based on the *likely* natural progression of the condition and not on a speculative estimate of what *could* happen to the injured employee in the future, however remote.

Medical Eligibility For Qualified Injured Worker Status

It is the primary treating physician who is in the best position to determine whether or not the injured employee will be able to return to gainful employment and in what capacity. This opinion, however, may be challenged by the injured employee, the employer or the insurance carrier. Additional information regarding the employee's permanent and stationary status and/or ability to perform his/her usual job, modified job or *any job* may then be sought from other evaluators. This is less likely to occur where the treating physician is well informed on such assessment. (See also Chapters IV, Disability Management/ERTW and Chapter VIII, Vocational Rehabilitation.)

CHAPTER X

Report Writing In The Dispute Resolution Process

Most patients with a work-related injury or illness will fully recover to their pre-injury state of health and return to work without incident. Occasionally, disputes arise over the cause of the injury, the nature of the treatment, extent of disability or medical eligibility for vocational rehabilitation. This necessitates legal processes to resolve these disputes.

Prior to January 1, 1994, procedures for dispute resolution did not take into consideration the opinions of the treating physician, except on the issue of vocational rehabilitation. Legislative changes altered that. For injuries occurring on or after January 1, 1994, the treating physician must provide his or her opinions on all medical issues necessary to determine eligibility for compensation. Usually, these opinions are given in the form of a narrative report. Legislative changes effective January 1, 1999 further codify the responsibilities of the Primary Treating Physician (PTP). [CCR §9785.] (See Appendix A.) The PTP also receives reports from all other health care providers to whom the injured employee has been referred, comments on and incorporates these reports into the PTP report, and submits all reports to the payor.

When there is a dispute, the treating physician may be requested by the patient's attorney, the insurer or the Workers' Compensation Appeals Board to provide a comprehensive medical-legal evaluation to assist in resolving the disputed issue(s). For injuries on or after January 1, 1994, the primary treating physician's opinion is given increased importance if there is a dispute regarding benefit eligibility. The PTP is presumed to be correct unless there is substantial evidence to the contrary. In most cases, a judge will rule according to the PTP report if it is well reasoned, logical and complete.

If the PTP's opinion is disputed by the employer or carrier and the injured employee is not represented by an attorney, the injured employee may select a Qualified Medical Evaluator (QME) from a panel assigned by the Industrial Medical Council to resolve the disputed issue. When the injured employee is represented by an attorney, a party who disputes the primary treating physician's findings may seek agreement with the other party to obtain a comprehensive medical-legal evaluation from an Agreed Medical Evaluator (AME). If no agreement is made, the disputing party may unilaterally obtain an opinion from a Qualified Medical Evaluator (QME). When this occurs, the treating physician's report is still presumed to be correct. This presumption is rebuttable, however, and may be controverted by a preponderance of other medical opinion. The presumption does not apply if both parties obtain QME opinions.

The Comprehensive Medical-Legal Evaluation

A medical-legal evaluation must be capable of proving or disproving a disputed medical issue concerning:

- the employee's medical condition (diagnosis);
- the cause of the employee's medical condition (AOE/COE);
- treatment of the employee's medical condition;
- the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition;
- the employee's medical eligibility for vocational rehabilitation services. [CCR §9793.]

Most medical-legal evaluations are conducted by Qualified Medical Evaluators (QME), or Agreed Medical Evaluators (AME). They provide written expert medical opinions regarding any of the above issues in lieu of testimony in court.

Comprehensive medical-legal evaluations should include sufficient information for a determination of the injured employee's entitlement to current and future medical treatment, vocational rehabilitation assessment and temporary and/or permanent disability payments. See the end of this chapter for a format conforming to the requirements for a medical-legal report.

The California Industrial Medical Council has published a revised *Physician's Guide to Medical Practice in the California Workers' Compensation System (2nd Edition)* that goes into detail on medical-legal reporting beyond the scope of this Manual For The Treating Physician. The *Physician's Guide to Medical Practice in the California Workers' Compensation System (2nd Edition)* can be ordered using the form in Appendix D: Resources.

Clarity Is Essential

When you are asked for a medical-legal report, the most important factor to keep in mind is that the report is being read by lay people who depend on the evaluating physician to logically develop and clearly explain the medical conclusions. The physician must not only include the findings and conclusions, but also the rationale behind the medical opinions. If there is an apparent inconsistency in the evaluation, (e.g., no significant objective findings but work is restricted) the reasons for this inconsistency should be explained in detail.

In writing the evaluation, the physician should select words carefully. Words such as “guess” or “speculate” should not be used. Such words will make the opinions appear ambiguous. Also, it is important to distinguish between possibility and probability. In California, the phrase, “reasonable medical probability,” is the accepted terminology for defending medical conclusions. This implies that the opinion is “more likely than not” or has a greater than 50% probability of being true. Use of the word “possible” implies that the chance of it being true is less than 50%.

The PTP may occasionally need to utilize the expertise of a specialist or another health care provider, such as physical therapist, to render medical opinions regarding specific issues. If this is the case, the secondary provider shall submit a report to the primary physician who must discuss those findings within the body of his or her report and attach the specialist’s reports as a reference.

Medical-legal evaluations are necessary only when there is a formal dispute. If there is no formally disputed issue, a final narrative supplemental report is sufficient.

Sample

Evaluating Physician
Medical-Legal Evaluation

Date of Report

Addressed to requesting party
(AME Reports are addressed to the appropriate WCAB, dependent on the patient's zip code.)

Re: (Patient's name)
Employer:
DOI:
Claim Number:

Dear:

Identifying Data

Mr./Mrs./Ms. _____is a (age) -year-old, (race/ethnic group) (male/female), who is being evaluated by myself in the capacity of (Qualified Medical Evaluator, or Agreed Medical Evaluator, or Primary Treating Physician) on _____(date) for_____ (the scope of the examination).

He/She is accompanied by a(n)_____-speaking interpreter, ___ (name and certification number)__ who participated in _____.

History Of The Present Injury/Illness As Presented By The Patient

Include a factual account of when, how and what happened as a result of the injury.

What did the patient describe at the onset of the injury/illness?

What happened after the injury? Did the patient continue working?

Was the injury reported? If so, to whom?

If there were multiple injuries, detail each injury and subsequent treatment and events.

Were there any witnesses to the injury?

What was the patient doing prior to the injury?

How was the patient referred to you for treatment? Employer? Friend? Attorney?

Add any other relevant information regarding what the patient has claimed happened before, during or after the injurious exposure, continuous trauma or specific incident.

Present Complaints

Describe in the patient's words how he/she is feeling at present.

What makes him/her feel better or worse and why? Include frequency, duration, intensity of any symptoms.

How is the injury/illness affecting his/her lifestyle?

Does he/she feel the treatment received has been of help?

Have there been any subsequent injuries/accidents?

Past Medical History

Are there any pre-existing injuries or illnesses?

Any prior personal injury or worker compensation claims?

Note any discrepancies between the injured employee's statements and prior medical records.

Family History

Note any pertinent familial medical history.

Social History

List the patient's marital status, children and their ages.

List any hobbies, sports activities.

Describe any habits, such as smoking, drinking or drugs (legal or illegal).

Occupational History

Include any relevant prior employment. (This is especially important for continuous trauma or occupational disease claims.)

Try to elicit the name and city of prior employers and the nature of his/her job.

Is the patient currently employed? If so, what is his/her occupation?

If the patient is no longer employed at the same job where the injury took place, why not?

Job Description

Include job title and a description of the patient's job duties at the time of the injury/illness.

What were the physical demands of the job?

Subsequent Treatment and Events

Describe any treatment received from you or anyone else due to the injury/illness.

List any current medications.

Physical Exam

Include your clinical findings and measurements, if appropriate to the injury, (e.g., grip strength, ROM, etc.).

Diagnostic Testing

Describe the tests that were administered, their purpose and results.

Comment on the relevancy and consistency with the diagnosis.

Diagnoses

Give the diagnosis and ICD-9 for each condition you are evaluating.
Do not list differential diagnoses.

Record Review

List any medical records or research that were reviewed in preparation of this evaluation, or any non-medical information received from any party that was a source for your opinions.

Causation

Give your best medical opinion regarding the relationship of the injury/exposure to the patient's current disability.

Disability Status

Has the injured employee returned to pre-injury status with no disability?

Is the patient permanent and stationary?

If not, what further treatment is necessary and when should the patient be evaluated?

Disability Factors (If Permanent and Stationary)

Subjective: Make every effort to use ratable terminology. (See Appendix C and Chapter VIII.)

Objective: List any pertinent findings based on your clinical exam or diagnostic testing.

Work Restrictions

Describe in ratable terminology any work restrictions indicated for the patient relative to the open labor market. Work restrictions may be actual or preventive (prophylactic), but must be consistent with objective and subjective findings. If using a restriction, it must be to prevent an increase in symptoms or permanent disability, or to prevent exacerbation requiring further medical care. Either type of work restriction, actual or preventive, will result in the same rating for the injured employee.

Loss Of Pre-Injury Capacity

Describe what the patient could do before the injury, compared to what the patient can do after the injury. The loss should be expressed in terms of a percentage.

Apportionment

Address only if applicable. (See Appendix C.)

Vocational Rehabilitation/Qualified Injured Worker Status

Is the patient medically eligible for vocational rehabilitation? Why?

Glossary Of Common Terminology

In the Workers' Compensation arena, not unlike the practice of medicine, many words and phrases are actually "Terms of Art" which convey a specific meaning to all practitioners of the discipline. The following words and phrases have specific meanings in the Workers' Compensation field and should be clearly understood when used by the primary care physician.

Administrative Director (AD) – The Administrative Director of the Division of Workers' Compensation (DWC). [Labor Code §3206.]

Adjuster – A representative of the insurer who coordinates payment for disability and medical treatment. Adjusters may be salaried employees of adjusting organizations operated by insurance companies, individuals operating independently and engaged by the companies to adjust a particular loss, special agents or staff adjusters, or staff adjusters employed by the insurer.

Aggravation – A change in a pre-existing conditions which causes a temporary or permanent increase in disability, or creates a need for additional or different medical treatment. The aggravation may be caused by either a new injury or by work activity.

Agreed Medical Evaluator – A physician, selected by agreement between the employer and the employee to resolve disputed medical issues referred by the parties in a workers' compensation proceeding. [8CCR §1(b).]

Alternative Work Assignment – Placement of an injured employee in another position with the same employer as a temporary or permanent accommodation to the employee's disability.

AOE/COE – Arising Out of Employment and in the Course of Employment - a criterion for determining liability, or whether a claim is or is not compensable. AOE refers to how the activity of work led to the injury in question. COE refers to how the activity the employee was engaged in at the time of injury must grow out of, or be incidental to, the employment. [LC §3600.]

Appeals Board – The Workers' Compensation Appeals Board (WCAB) of the Division of Workers' Compensation. [LC §3205.5.]

Apportionment – The process of determining if some portion of an injured employee's permanent disability is due to a cause other than the current injury. Apportionment applies only to permanent disability.

Arise Out Of Employment (AOE) – The injury is proximately caused by the employment, either with or without negligence on the part of the employee. [LC §3600(a)(3).]

Average Weekly Wages (AWW) – The employees ability to earn wages, including tips, gratuities, and non-monetary earnings, expressed as a weekly earnings amount. Determination of AWW is made using the earnings from up to the 12 months (52 weeks) previous to the injury and divided by the actual number of weeks used.

Claim – A claim for compensation as evidenced by either the filing of a claim form pursuant to Section 5401 of the Labor Code, or notice of knowledge of an injury under Section 5400 or 5402 of the Labor Code. [8 CCR §9793(a).]

Claims Administrator – An employee of an insurance company, self-insured employer, third party administrator, or other organization, who processes or oversees the processing of individual workers' compensation claims. [8 CCR §9793(d).]

Constant Symptoms – Symptoms which occur between 75 - 100 percent of the time.

Course of Employment – At the time of the injury, the employee was performing service growing out of and incidental to his or her employment and was acting within the course of his or her employment at the time of the injury. [LC §3600(a)(2).]

Cumulative Injury – An injury that is the result of repetitive mental or physical trauma or exposure to an injurious substance over a period of time.

Date Of Injury (DOI) – In a specific injury, the date of injury (DOI) is simply the date that the incident or exposure occurred. In a cumulative injury or occupational illness, the DOI (for statute of limitation purposes) is the date when the employee first suffered disability from the exposure, and either knew or, "in the exercise of reasonable diligence", should have known that the disability was caused by present or previous employment. Often that date is also the last day worked.

Delayed Recovery - The failure to regain functional capacity within the expected time period, given the nature of the injury or illness.

Disability – The inability or reduced ability to compete in the open labor market due to the effects of a physical or mental injury.

Disability: **Permanent Partial Disability** – A permanent disability with a rating of less than 100 percent permanent disability. [LC §4452.5(b).]

Disability: **Permanent Total Disability** – A permanent disability with a rating of 100 percent permanent disability. [LC §4452.5(a).]

Disputed Medical Fact – An issue in dispute, including an objection to a medical determination made by a treating physician, under §4062 of the Labor Code concerning:

(1) the work-relatedness of the employee's medical condition;

(2) the Permanent and Stationary status of the employee's medical condition;

(3) the employee's preclusion or likely preclusion to engage in his or her usual occupation;

(4) the extent and scope of medical treatment;

(5) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition; or

(6) any other medical issue.

Doctors First Report of Injury (DFR) – The report required by the Department of Industrial Relations, through its Division of Labor Statistics and Research, to be filed by every physician who attends any injured employee within five (5) days of the initial examination. [LC §6409.]

Early Return To Work (ERTW) – The process of bringing an injured employee who is not fully recovered safely back to work, as early as possible within his or her functional capacity as defined by the primary treating physician, smoothing and expediting the transition from injury or illness to productivity. This should be viewed as a transitional position, gradually increasing the demands of the position with the goal of returning the employee to pre-injury status.

First Aid – Any one-time treatment including any follow-up, of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation is considered first aid, even though provided by a physician or registered professional personnel. [8 CCR §14311(c).]

Frequent Symptoms – Symptoms that occur between fifty and seventy five percent of the time.

Full Time Employee – An employee who works 30 hours or more per week. [LC §4453(c).]

Impairment – A measure of anatomic or psychologic loss. Defined by the World Health Organization as "any loss or abnormality of psychological, physiological, or anatomical structure or function." In the California Workers' Compensation System, impairment is a medical determination.

Injury – Any injury or disease arising out of the employment, including injuries to artificial members, dentures, hearing aids, eyeglasses and medical braces of all types; provided, however, that eyeglasses and hearing aids will not be replaced, repaired, or otherwise compensated for, unless injury to them is incident to an injury causing disability. [LC §3208.]

Injury; **Specific And Cumulative** – An injury may be either: (a) "specific," occurring as the result of one incident or exposure which causes disability or need for medical treatment; or (b) "cumulative," occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. [LC §3208.1.]

Insurer – This includes the State Compensation Insurance Fund and any private company, corporation, mutual association, reciprocal or interinsurance exchange authorized under the laws of this state to insure employers against liability for compensation, and any employer to whom a certificate of consent to self-insure has been issued. [LC §3211.]

Intermittent Symptoms – Symptoms that occur twenty five to fifty percent of the time.

Job Description – A written document prepared by the employer detailing the activities, duties and responsibilities of a particular job.

Loss of Pre-injury Capacity – The change in an individual's capacity to perform physical or other activities, comparing the individual's capability before the injury with the capability after the injury has stabilized.

Maximum Medical Improvement – See "Permanent And Stationary."

Medical-Legal Evaluation – An evaluation of an employee which: (a) results in the preparation of a narrative medical report prepared and attested to in accordance with §4628 of the Labor Code, any applicable procedures promulgated under §139.2 of the Labor Code, and the requirements of Title 8 C.C.R. §10606; and (b) which either is:

(1) performed by a Qualified Medical Evaluator pursuant to subdivision (h) of §139.2 of the Labor Code, or

(2) performed by a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician for the purpose of proving or disproving a contested claim, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (g) of Title 8, California Code of Regulations, §9793.

Medical-Legal Expense – Any costs and expenses incurred by or on behalf of any party, the administrative director, the board, or a referee for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. [LC §4620(a).]

Medical-Legal Testimony – Expert testimony provided by a physician at a deposition or Workers' Compensation Appeals Board hearing, regarding the medical opinion submitted by the physician. [8 CCR §9793(h).]

Medical Treatment – Any medical, surgical, chiropractic and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches and apparatus, including artificial members, that is reasonably required to cure or relieve from the effects of the injury. [LC §4600.]

Minimal Pain – Pain that would constitute an annoyance but cause no handicap in the performance of the particular activity and would be considered a nonratable permanent disability.

Moderate Pain – Pain that could be tolerated but would cause marked handicap in the performance of the activity precipitating the pain.

Modified Work – A work assignment for an injured employee that has been changed to enable the injured employee to perform in that position. Examples include modifying the work station so the job can be performed seated instead of standing, or modifying the content of the work to exclude tasks the employee can no longer perform.

Objective Factors – Factors of impairment that can be directly measured, observed, or demonstrated and are appropriately interpreted. Included are physical findings such as range of motion, strength, findings on X-ray, and the results of laboratory or other diagnostic tests.

Occasional Symptoms – Symptoms that occur less than twenty-five percent of the time.

Occupational Illness – Any abnormal condition or disorder caused by exposure to environmental factors associated with employment, including acute and chronic illnesses or diseases which may be caused by inhalation, skin absorption, ingestion or direct contact. [8CCR §14000.]

Official Medical Fee Schedule (OMFS) – The schedule, adopted and revised by the Administrative Director of the California Division of Workers' Compensation, which

establishes reasonable maximum fees paid for workers' compensation health care services provided by physicians within their scope of practice. [LC §5307.1(a)(1).]

Part-time Work – Regular employment of less than 30 hours per week for one employer.

Permanent And Stationary (P&S) – An employee's medical condition is considered permanent and stationary after it has medically stabilized (sometimes called "maximum medical improvement" although some slight medical improvement might be anticipated in the future), or when the condition has been stationary for a "reasonable period of time."

Permanent Disability – Disability that is expected to continue for the lifetime of the injured employee and results in a diminished capacity to compete in the open job market. This diagnosis is made by a physician as defined by the California Labor Code, and is made after the injured employee reaches a status that is Permanent and Stationary (P&S). Permanent Disability may be Partial or Total. Permanent Partial Disability is a disability with a rating of less than 100 percent. Permanent Total Disability is a permanent disability with a rating of 100 percent disability.

Permanent Disability Compensation – Indemnity payments intended to compensate an injured employee for impairment resulting from an industrial injury or illness which lessens the employee's ability to compete in the open labor market. It is not intended as a wage replacement or to compensate the employee for pain and suffering.

Permanent Disability Rating – A determination of the percentage of total disability for the individual injured employee. The law requires that consideration be given to the nature of the injury, the occupation and age of the injured employee at the time of the injury, and the extent to which the injured employee has diminished ability to compete in the open job market.

In determining permanent disability, it is disability that is rated, not the existence of a pathological condition. Thus, an industrial disease is not rated but rather its permanent effect on the employee's working ability. The DWC uses the "Schedule for Rating Permanent Disabilities" to determine applicable permanent disability percentages based on the information provided by physicians.

Physician – This includes physicians and surgeons holding an MD or DO degree, psychologists, acupuncturists, optometrists, dentists, podiatrists and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law. [LC §3209.3(a).]

Preponderance of the Evidence – Evidence that, when weighed with that opposed to it, has more convincing force and the greater probability of truth. When weighing the evidence, the test is not the relative number of witnesses, but the relative convincing force of the evidence.

Primary Treating Physician (PTP) – The primary treating physician is the physician selected by the employer or the employee under the contract or procedure applicable to a Health Care Organization. The physician who is primarily responsible for managing the care of an injured employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. There shall be no more than one primary treating physician at a time. The PTP shall be

responsible for obtaining all of the reports of other treating and/or consulting physicians and shall incorporate or comment upon those reports and attach all of the reports for submission to the employer/insurer. [CCR §9785.5.]

Psychologist – A licensed psychologist with a doctoral degree in psychology or a doctoral degree deemed equivalent for licensure by the Board of Psychology, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology. [LC §3209.3(b).]

Qualified Injured Worker – An employee who meets both of the following requirements:

(1) The employee's expected permanent disability as a result of the injury, whether or not combined with the effects of a prior injury or disability, if any, permanently precludes or is likely to preclude the employee from engaging in his or her usual occupation or the position in which he or she was engaged at the time of injury, hereafter referred to as *medical eligibility*.

(2) The employee can reasonably be expected to return to suitable gainful employment through the provision of vocational rehabilitation services, hereafter referred to as vocational feasibility.

Qualified Medical Evaluator (QME) – A physician who has been appointed and certified by the IMC to conduct medical-legal evaluations of injured employees.

Reasonable Accommodation – Any modification or adjustment to a job or the work environment that will enable a qualified applicant or employee with a disability to participate in the application process or to perform essential job functions.

Rebuttable Presumptions – An assumption that can carry the burden of proof for the party entitled to its benefits. It may be overcome by evidence presented by the opposing party. In workers' compensation, rebuttable presumptions exist that certain conditions are employment related for certain groups of employees. In effect, this presumption shifts the burden of proof to the employer who must then show that the condition was not caused by work, or the injury will be found compensable.

Represented Employee – An injured employee who is represented by an attorney.

Self-Insured Employer – An employer who has secured from the Director of Industrial Relations a certificate of consent to self-insure against Workers' Compensation claims pursuant to Labor Code §3700.

Severe Pain – A pain that would preclude the activity precipitating the pain.

Slight Pain – A pain that can be tolerated but that will cause some handicap in the performance of the activity precipitating the pain.

Subjective Factors – Symptoms that interfere with the injured employee's ability to work that cannot be objectively measured, that are obtained from the injured employee's description of symptoms, and need some degree of interpretation by the physician. This includes pain and emotional symptoms, especially those which the patient describes as limiting particular activities.

Temporary Disability – Disability which precludes the injured employee from working for a period of time roughly equal to the post-traumatic convalescent period. Temporary disability can be total (temporary total disability or TTD) or partial (temporary partial disability or TPD) and may or may not result in permanent disability. Compensation is paid to the injured employee during the period of disability. The compensation paid is based on the earnings of the injured employee at the time of injury with statutory minimum and maximum rates.

Transitional Work – Short-term positions lasting less than 90 days, requiring little or no additional training and designed so that the employee performing the temporary modified or alternate work contributes to the productivity of the unit in a measurable way.

Unrepresented Employee – An injured employee who is not represented by an attorney.

Utilization Review - "Utilization review" is a system used to manage costs and improve patient care and decision-making through case by case assessments of the frequency, duration, level and appropriateness of medical care and services to determine whether medical treatment is or was reasonably required to cure or relieve the effects of the injury.

Wage Loss – Two-thirds the difference between Average Weekly Wages and the injured employee's actual earnings up to a statutory maximum rate, while still temporarily partially disabled (TPD) but working at modified work or a reduced work schedule.

Waiting Period – The period of time (three days) for which no compensation is paid unless the Injured employee is hospitalized as an inpatient or remains disabled beyond 14 days (for injuries occurring on or after 1/1/90). This period begins on the first day for which the Injured employee did not receive full pay as a result of the industrial injury.

Work Restrictions – Temporary or permanent restrictions of specific activities, body positions, motions, exposure, and time limitations that have been placed on the injured employee by the treating or consulting physicians to facilitate recovery from the injury. Restrictions can be actual (due to an inability to perform the activity) or prophylactic (designed to prevent further injury). Permanent work restrictions are ratable disabilities.

APPENDIX A

Relevant Labor Code Sections

Doctor's First Report of Occupational Injury Or Illness

(Reprinted by permission of Matthew Bender, Inc. Pub. 840, 1998 edition)

Rule Of Practice And Procedure, CCR §14003:

(a) Every physician, **as defined in Labor Code §3209.3**, who attends an injured employee shall file, within five days after initial examination, a complete report of every occupational injury or illness with the employer's insurer, or with the employer, if self-insured. The injured or ill employee, if able to do so, shall complete a portion of such report describing how the injury or illness occurred. Unless the report is transmitted on computer media, the physician shall file the original signed report with the insurer or self-insured employer.

(b) If treatment is for pesticide poisoning or for a condition suspected to be pesticide poisoning, the physician shall also file a complete report directly with the Division within five days after initial treatment. In no case shall treatment administered for pesticide poisoning be deemed to be first aid treatment.

(c) The reports required by this section shall be made on Form 5021, Rev. 4, Doctor's First Report of Occupational Injury or Illness, upon a form reproduced in accordance with §14007, or by use of computer input media prescribed by the Division and compatible with the Division's computer equipment.

(d) Physicians who use computerized data collection and reporting systems shall keep the injured employee's statement with the patient's medical records.

Treating Physician To Render Opinions On Medical Issues Needed To Determine Eligibility For Compensation

(Reprinted by permission of Matthew Bender, Inc. Pub. 840, 1998 edition)

Labor Code §4061.5:

The treating physician primarily responsible for managing the care of the injured employee or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all medical issues necessary to determine eligibility for compensation. In the event that there is more than one treating physician, a single report shall be prepared by the physician primarily responsible for managing the injured employee's care that incorporates the findings of the various treating physicians.

California Code of Regulations
Title 8, Division 1, Chapter 4.5, Subchapter 1, Article 5

§9785. Reporting Duties of the Primary Treating Physician

(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an injured employee and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer or the employee pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under Section 4600.5 of the Labor Code.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the injured employee, but is not primarily responsible for continuing management of the care of the injured employee.

(3) "Claims Administrator" is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(b) There shall be no more than one primary treating physician at a time. Where the primary treating physician discharges the employee from further treatment and there is a dispute concerning the need for continuing treatment, no other primary treating physician shall be identified unless and until the dispute is resolved. If it is determined that there is no further need continuing treatment, then the physician who discharged the employee shall remain the primary treating physician. If it is determined that there is further need for continuing treatment, a new primary treating physician may be selected.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. However, a claims administrator may designate any person or entity to be the recipient of the required reports.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation–in the manner prescribed in

subsections (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e) (1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following each visit. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination.

(3) Secondary physicians, physical therapists, and other health care providers to whom the injured employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall incorporate, or comment upon, the opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall promptly report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices.

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is discharged.

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging

in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code §4636(b).

(7) The employer reasonably requests additional appropriate information;

(8) When ongoing treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred.

Reports required under this subdivision shall be submitted on the form entitled "Primary Treating Physician's Progress Report," Form PR-2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2.

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall report any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing or future medical care resulting from the injury. The information may be submitted on the form entitled "Treating Physician's Permanent and Stationary Report," Form PR-3, or using the instructions on the form entitled "Treating Physician's Determination of Medical Issues Form," Form IMC 81556, or in such other manner as provides all the information required by Title 8, California Code of Regulations, §10606. Qualified Medical Evaluators and Agreed Medical Evaluators may not use Form PR-3 to report medical-legal evaluations.

(h) Any controversies concerning this section shall be resolved pursuant to Labor Code §4603 or §4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

Note: Authority Cited: Sections 139.5, 4061.5, 4603.2, 4603.5, 5307.3, Labor Code. Reference: Sections 4600, 4061.5, 4603.2, 4636, Labor Code.

Primary Treating Physician Regulations
Effective: January 1, 1999

California Code of Regulations
Title 8, Division 1, Chapter 4.5, Subchapter 1, Article 5.5

§9792.6. Utilization Review Standards

(a) As used in this section:

(1) "Insurer" means a workers' compensation insurer, or an employer securing its liability under subdivision (b) or (c) of Section 3700 of the Labor Code.

(2) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(3) "Health care provider" means a provider of medical services, including an individual provider, a health care service plan, a health care organization, or a preferred provider organization.

(4) "Request for authorization" means any written request for assurance that appropriate reimbursement will be made for a specific course of proposed medical treatment set forth in Form DLSR 5021, Section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of Section 9785. A verbal request for authorization or a written confirmation of a verbal authorization is a not a "request for authorization" for purposes of this article.

(5) "Utilization review" is a system used to manage costs and improve patient care and decision-making through case by case assessments of the frequency, duration, level and appropriateness of medical care and services to determine whether medical treatment is or was reasonably required to cure or relieve the effects of the injury.

(6) "Written" includes an electronic facsimile or electronic mail, as well as communications in paper form.

(b) No later than July 1, 1996, any insurer which implements or maintains a system of utilization review shall maintain and make available to the administrative director upon request, a written summary of the insurer's utilization review system, including:

(1) A description of the process whereby requests for authorization are reviewed and decisions on such requests are made, including a concise description of how the requirements in subdivision (c) are met by the process.

(2) A description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process. It shall include a description of the personnel and other sources used in the development and review of the criteria, and methods for up-dating the criteria.

(3) A description of the qualifications of the personnel involved in implementing the utilization review system and the manner in which these personnel are involved in the review process.

(c) Any utilization review system shall comply with the following minimum standards:

(1) Upon receipt of a written request for authorization, an insurer shall issue a written authorization, denial, or notice of delay of decision to the health care provider, which shall be transmitted or placed in the U.S. mail no later than seven working days after the insurer's receipt of the request and any necessary supporting documentation. The authorization, denial, or notice of delay shall include some means of identification of the request, and shall include the name and phone number of a responsible contact person. A notice of delay shall state what additional information is required to make a decision and when a decision regarding the request is expected to be made.

(2) An insurer may use a non-physician reviewer to initially apply medically-based criteria to requests for authorization or to bills for medical services, but no request for authorization shall be denied, and no request for payment shall be denied or reduced on the basis that the services provided were not reasonably required to cure or relieve the injury, except by a physician with an unrestricted license by his or her licensing board who has education, training, expertise, and experience that is pertinent for evaluating the specific clinical issues or services under review.

(3) Only medically-based criteria shall be used in the utilization review and decision-making process. The criteria applied in a particular case shall be made available to the affected health care provider and injured employee upon his or her written request. The criteria shall:

(i) be based on professionally-recognized standards;
(ii) be developed using sound clinical principles and processes;
(iii) be developed by physicians, with involvement of actively practicing health care providers, and be peer-reviewed;
(iv) be evaluated at least annually and updated if necessary;
(v) be signed and dated by the physicians responsible for development.

(4) If an insurer denies a request for authorization, or denies or reduces a bill for medical services on the basis that the services were not reasonably necessary to cure or relieve the effects of the injury, and the health care

provider has not agreed to the denial or reduction, a written explanation of the basis of the denial or reduction must be submitted to the health care provider which includes:

(i) the name of the reviewer;
(ii) the telephone number of the reviewer, and hours of availability;
(iii) the medical criteria upon which the denial is based.

Authorization may not be denied on the basis of lack of information without documentation of a bona fide attempt to obtain the necessary information.

(d) Each insurer which implements or maintains a system meeting the requirements of this section shall advise the administrative director, as soon as practicable, of the date the system will be operational.

(e) If the administrative director finds that an insurer has implemented or maintained a utilization review system on or after July 1, 1996 which does not comply with this section, the administrative director shall notify the insurer in writing of such finding and provide the insurer with a reasonable period of time, not to exceed 90 days, to correct the noted deficiency. If the administrative director finds that revised system still does not comply with this section, he or she may take such action authorized under Labor Code Section 129.5 as deemed appropriate under the circumstances.

Note: Authority Cited: Sections 133, 139, 4601.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 129.5, 3211, 3702, 4600, 4601.5, 4603.2 and 5307.1 Labor Code.

(UR Regulation. 8 CCR §9792.6.)
[Final - effective January 1, 1999.]

Physicians' Report As Evidence

(Reprinted by permission of Matthew Bender, Inc.. Pub. 840, 1998 edition)

Rule Of Practice And Procedure, CCR §10606:

The Workers' Compensation Appeals Board favors the production of medical evidence in the form of written reports. Direct examination of a medical witness will not be received at a hearing except upon a showing of good cause and written notice to the parties filed and served at least 10 days before the hearing. A continuance may be granted for rebuttal testimony subject to Labor Code §5502.5.

These reports should include, where applicable:

(a) The date of the examination;

(b) The history of the injury;

(c) The patient's complaints;

(d) A listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion:

(e) The patient's medical history, including injuries and conditions, and residuals thereof, if any;

(f) Findings on examination;

(g) A diagnosis;

(h) Opinion as to the nature, extent, and duration of disability and work limitations, if any:

(i) Cause of the disability;

(j) Treatment indicated;

(k) Opinion as to whether or not permanent disability has resulted from the injury and whether or not it is stationary. If stationary, a description of the disability with a complete evaluation;

(l) Apportionment of disability, if any;

(m) A determination of the percent of the total causation resulting from actual events of employment, if the injury is alleged to be a psychiatric injury;

(n) The reasons for the opinion; and,

(o) The signature of the physician.

Failure to comply with (a) through (o) will be considered in weighing such evidence.

In death cases, the reports of non-examining physicians may be admitted into evidence in lieu of oral testimony.

All medical reports shall comply with the provisions of Labor Code §4628.

Except as otherwise provided by the Labor Code, including Labor Code §4628 and §5703 and the rules of practice and procedure of the Appeals Board, failure to comply with the requirements of this section will not make the report inadmissible but will be considered in weighing such evidence.

Responsibilities Of The Physician Signing Medical-Legal Reports

(Reprinted by permission of Matthew Bender, Inc., Pub. 840, 1998 edition)

Labor Code §4628:

(a) Except as provided in subdivision (c), no person, other than the physician who signs the medical-legal report, except a nurse performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the non-clerical preparation of the report, including all of the following:

(1) Taking a complete history.

(2) Reviewing and summarizing prior medical records.

(3) Composing and drafting the conclusions of the report.

(b) The report shall disclose the date and location where the evaluation was performed; that the physician or physicians signing the report actually performed the evaluation; whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of §139.2 or §5307.6 and shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation. If the report discloses that the evaluation performed or the time spent performing such evaluation was not in compliance with the guidelines established by the Industrial Medical Council or the administrative director, the report shall explain, in detail, any variance and the reason or reasons therefor.

(c) If the initial outline of a patient's history or the excerpting of prior medical records is not done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

(d) No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.

(e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.

(f) Knowing failure to comply with the requirements of this section shall subject the physician to a civil penalty of up to one thousand dollars ($1,000) for each violation to be assessed by a Workers' Compensation judge or the appeals board.

(g) A physician who is assessed a civil penalty under this section may be terminated, suspended, or placed on probation as a qualified medical evaluator pursuant to subdivisions (k) and (l) of §139.2.

(h) Knowing failure to comply with the requirements of this section shall subject the physician to contempt pursuant to the judicial powers vested in the appeals board.

(i) Any person billing for medical-legal evaluations, diagnostic procedures, or diagnostic services performed by persons other than those employed by the reporting physician or physicians, or a medical corporation owned by the reporting physician or physicians, shall specify the amount paid or to be paid to those persons for the evaluations, procedures or services. This subdivision shall not apply to any procedure or service defined or valued pursuant to §5307.1.

(j) The report shall contain a declaration by the physician signing the report, under penalty of perjury, stating:

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information provided to me and, except as noted herein, that I believe it to be true."

The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county wherein it was signed.

(k) The physician shall provide a curriculum vitae upon request by a party and include a statement concerning the percent of the physician's total practice time that is annually devoted to medical treatment.

Comprehensive Medical-Legal Evaluation

(Reprinted by permission of Matthew Bender, Inc. Pub. 840, 1998 edition)

Labor Code §4060:

(a) This section shall apply to disputes over the compensability of any injury. This section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer.

(b) Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician either in whole or in part on behalf of the employee prior to the filing of a claim form and prior to the time the claim is denied or becomes presumptively compensable under §5402. However, reports of treating physicians shall be admissible.

(c) If a medical evaluation is required to determine compensability at any time after the period specified in subdivision (b), and the employee is represented by an attorney, each party may select a qualified medical evaluator to conduct a comprehensive medical-legal evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The parties may, at any time, agree on one medical evaluator to evaluate the issues in dispute.

(d) If a medical evaluation is required to determine compensability at any time after the period specified in subdivision (b), and the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare a comprehensive medical-legal evaluation. The employee may select a qualified medical evaluator to prepare a comprehensive medical-legal evaluation. The division shall assist unrepresented employees, and shall make available to them the list of medical evaluators compiled under §139.2. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. If an employee has received a comprehensive medical-legal evaluation under this subdivision, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation at the employer's expense.

(e) Evaluations performed under this section shall not be limited to the issue of the compensability of the injury, but shall address all medical issues in dispute.

APPENDIX B

Links to Forms

Doctor's First Report of Occupational Injury or Illness
DWC, State of CA (DWC Form 5021, 1992)
http://www.dir.ca.gov/dlsr/dlsrform5021.pdf

Primary Treating Physician's Progress Report (PR-2)
DWC, State of CA (DWC Form PR-2, rev. 1/1/99)
http://www.dir.ca.gov./DWC/PR-2.pdf

Treating Physician's Determination of Medical Issues
IMC, State of CA (IMC Form 81556)
http://www.dir.ca.gov/imc/FormIMC81556.pdf

APPENDIX C

Permanent Disability Guidelines

Sample Disability Standards

Guidelines For Work Capacity [1]

These apply to neck, back, pelvis, pulmonary, heart disease, and abdominal weakness.

GUIDELINES g) AND h) MAY APPLY TO LOWER EXTREMITY DISABILITIES

Disability Precluding Very Heavy Lifting
contemplates the individual has lost approximately 25% of his pre-injury capacity for lifting.
(A statement "inability to lift 50 pounds" is not meaningful. The total lifting effort, including weight, distance, endurance, frequency, body position and similar factors should be considered with reference to the particular individual.)

Disability Precluding Very Heavy Work
contemplates the individual has lost approximately 25% of his pre-injury capacity for performing such activities as bending, stooping, lifting, pushing, pulling, and climbing or other activities involving comparable physical effort.

Disability Precluding Repetitive Motions of Neck or Back
contemplates the individual has lost approximately 50% of his pre-injury capacity for flexing, extending, bending, and rotating neck or back.

Disability Precluding Heavy Lifting
contemplates the individual has lost approximately 50% of his pre-injury capacity for lifting.
(See statement regarding lifting under "Very Heavy Lifting" above.)

Disability Precluding Heavy Lifting, Repeated Bending, and Stooping
contemplates the individual has lost approximately 50% of his pre-injury capacity for lifting, bending, or stooping.

Disability Precluding Heavy Work
contemplates the individual has lost approximately 50% of his pre-injury capacity for performing such activities as bending, stooping, lifting, pushing, pulling, and climbing or other activities involving comparable physical effort.

Disability Precluding Substantial Work
contemplates the individual has lost approximately 75% of his pre-injury capacity for performing such activities as bending, stooping, lifting, pushing, pulling, and climbing or other activities involving comparable physical effort.

Disability Resulting in Limitation to Light Work
contemplates the individual can do work in a standing or walking position, with a minimum of demands for physical effort.

Disability Resulting in Limitation to Semi-Sedentary Work
contemplates the individual can do work approximately one half the time in a sitting position, and approximately one half the time in a standing or walking position, with a minimum of demands for physical effort whether standing, walking, or sitting.

Disability Resulting in Limitation to Sedentary Work
contemplates the individual can do work predominantly in a sitting position at a bench, desk, or table with a minimum of demands for physical effort and with some degree of walking and standing being permitted.

1. Adapted from *Schedule For Rating Permanent Disabilities* under provisions of the Labor Code of the State of California. Department of Industrial Relations, Division of Workers' Compensation, April 1997.

EXTREMITY
MEASUREMENT CHART

Pateint's Name	Date Injured	Injured Extremity	Dominant Extremity

Upper Extremity

GRIP (Dynamometer)

INJURED	UNINJURED

Reliability: Good _____ Poor _____
If poor, what is estimated grip loss _____

SHOULDER

	INJURED	UNINJURED
Extension		
Flexion		
Int. Rotation		
Ext. Rotation		
Abduction		
Adduction		

ELBOW

	INJURED	UNINJURED
Extension		
Flexion		

FOREARM

	INJURED	UNINJURED
Pronation		
Supination		

WRIST

	INJURED	UNINJURED
Int. Rotation		
Ext. Rotation		
Abduction		
Adduction		

Lower Extremity

CIRCUMFERENCE (in inches)

	INJURED	UNINJURED
Thigh		
Calf		

HIP

	INJURED	UNINJURED
Extension		
Flexion		
Int. Rotation		
Ext. Rotation		
Abduction		
Adduction		

KNEE

	INJURED	UNINJURED
Extension		
Flexion		

ANKLE

	INJURED	UNINJURED
Dorsiflexion		
Plantar Flex.		
Inversion		
Eversion		

THUMB

	INJURED	UNINJURED
Prox. Jt. Ext.		
Prox. Jt. Flex.		
Dist. Jt. Ext.		
Dist. Jt. Flex.		
Abduction		
Adduction		

		PROXIMAL (INJ / UNINJ)	MIDDLE (INJ / UNINJ)	DISTAL (INJ / UNINJ)	FINGER TIP MISSES MID-PALM CREASE (IN INCHES)
INDEX	Flexion	/	/	/	/
	Extension	/	/	/	
MIDDLE	Flexion	/	/	/	/
	Extension	/	/	/	
RING	Flexion	/	/	/	/
	Extension	/	/	/	
LITTLE	Flexion	/	/	/	/
	Extension	/	/	/	

NOTE: I. Measurements not shown are considered normal.
II. All measurements, unless otherwise noted, are in degrees of active motion.

Signature _____ Date _____

All measurements should be made in accordance with the standard method as described in the book "Evaluation of Industrial Disability," by Packard Thurber, M.D., second edition, Oxford University Press 1960.

SAMPLE DISABILITY STANDARDS FROM IMPAIRMENT LEVELS

Note: The following table approximates the way in which a Rating Specialist translates a physician's assessment of impairment into a standard disability level. The impairment may be described either in terms of subjective findings or in terms of a work restriction. The first table would apply to spinal disabilities while the second is more useful in determining disability in the lower extremities.

Physician's description of impairment due to SPINAL INJURY	**Probable Standard Rating**
Intermittent minimal slight pain	3%
-or-	
Minimal to slight pain on strenuous work	
-or-	
Minimal pain and stiffness occasionally becoming slight	
Intermittent slight pain	5%
-or-	
Slight pain on heavy lifting	
-or-	
Minimal to slight constant pain	
-or-	
Minimal to slight constant dull ache	
Constant slight pain	10%
-or-	
Patient precluded from doing VERY heavy lifting	
-or-	
Moderate pain on heavy lifting	
-or-	
Constant slight pain with occasional momentary sharp pain	
-or-	
Constant minimal pain becoming slight on work activity	
Patient precluded from REPEATED heavy lifting	15%
-or-	
Patient precluded from VERY heavy lifting	
-or-	
Intermittent slight to moderate pain	
-or-	
Constant slight pain becoming moderate on certain occasions or activities	
-or-	
Moderate pain on heavy work	
-or-	
Patient has lost ¼ of his ability to do bending, lifting, and stooping	
Patient is precluded from heavy lifting	20%
-or-	
Patient is precluded from REPETITIVE forward bending or REPETITIVE heavy lifting	

-or-	
Slight pain made moderate on heavy work	
-or-	
Patient is precluded from prolonged weight bearing	
Patient is precluded from heavy lifting, and repetitive bending and stooping	25%
-or-	
Occasional severe pain	
Patient is precluded from doing heavy work	30%
-or-	
Constant slight to moderate pain	
-or-	
Patient has lost ½ of his capacity for pushing and pulling	
Constant slight to moderate pain which is made worse by prolonged walking, standing, or sitting	35%
-or-	
Patient is precluded from heavy lifting, repetitive bending or prolonged sitting or standing	
Patient is limited to work which falls between heavy and light	40%
Patient limited to light work	50%
-or-	
Moderate to severe pain	

	Rating
Patient is precluded from running or jumping	1%
Patient is precluded from running and jumping	2%
Patient is precluded from repetitive squatting or kneeling	3%
Patient is precluded from repetitive climbing or walking	3 to 5%
Patient is precluded from repetitive squatting, running, jumping, kneeling	3%
Patient is precluded from squatting, running, jumping, and kneeling	5%
Patient is precluded from squatting	5%
Patient is precluded from kneeling unilaterally	5%
Patient is precluded from squatting or kneeling	5%
Patient is precluded from walking on uneven terrain	10%
-or-	
Patient is precluded from climbing	
-or-	
Patient is precluded from walking aloft	
-or-	
Patient is precluded from climbing, running, jumping	
-or-	
Patient is precluded from prolonged walking	
-or-	
Patient is precluded from kneeling bilaterally	
-or-	
Patient is precluded from prolonged sitting	
Patient is precluded from prolonged pushing	10 to 15%
Patient is precluded from prolonged standing	15%
Patient is precluded from prolonged standing and walking	20%
Patient is precluded from prolonged weight bearing, climbing, running, jumping, walking on uneven ground	25 to 30%
-or-	
Patient is precluded from prolonged standing and walking/excessive climbing and squatting	
Patient is limited to heavy lifting, prolonged standing and walking, squatting, kneeling, working at heights, running or jumping	35%
Patient is precluded from semi-sedentary work	60 to 65%
-or-	
Patient is limited to selected types of light work	
-or-	
Patient is limited to work between sedentary and light	
-or-	
Patient is limited to VERY light work	
-or-	
Patient is precluded from all but the very lightest work	
-or-	
Patient needs to spend ½ of the time sitting and ½ of the time standing	
Patient is limited to sedentary work	70%

Patient is limited to VERY sedentary work	85%
-or-	
Patient is precluded from all but the most sedentary work	
-or-	
Patient is limited to selected types of sedentary work with the provision for occasional rest	
Patient is limited to half-time sedentary work	90%
Patient is precluded from all types of gainful employment	100%
-or-	
Patient is totally unable to compete in an open labor market	
-or-	
Constant severe pain	

Resources

This appendix lists government agencies, professional organizations and printed materials which may be helpful for the primary treating physician.

State Compensation Insurance Fund

District Offices

Each District Office is organized into Claims, Field Services, and Legal Departments. The Claims Department is responsible for all matters related to delivery of medical and disability benefits. Each Claims Department has an advanced claims administrator whose sole function is acting as the *Medical Community Liaison (MCL.)* The MCL facilitates communication between State Fund and the treating physicians. The individual claims administrator has primary responsibility for treatment authorization and oversight on individual claims.

Most District Offices have a full-time on-site registered nurse consultant to help the claims adjusters interpret medical information and make appropriate decisions about treatment authorization requests. All Districts also have a part-time on-site medical doctor to assist the nursing staff and/or claims adjusters. Some offices also use part-time physical therapy and chiropractic consultants. These licensed medical professionals are always involved when there are questions about authorization of medical treatment. (See Chapter V.) Medical technology research support is provided by staff in the State Fund Medical Director's Office.

List of State Compensation Insurance Fund District Offices

Bakersfield DO
9801 Camino Media
Bakersfield, CA 93311
Mailing Address: PO Box 21810
Bakersfield, CA 93390-1810
Claims Dept. Phone #: (661) 664-4065

Eureka DO
908 Seventh Street
Eureka, CA 95501
Mailing Address: PO Box 4973
Eureka, CA 95502-4973
Claims Dept. Phone #: (707) 443-9721

Fresno DO
10 River Park Place East
Fresno, CA 93720
Mailing Address: PO Box 40000
Fresno, CA 93755
Claims Dept. Phone #: (559) 433-2700

*Los Angeles DO/Monterey Park Location
900 Corporate Center Drive
Monterey Park, CA 91754
Mailing Address: PO Box 92622
Los Angeles, CA 90009-2622
Claims Dept. Phone #: (323) 266-5000

Woodland Hills Location
21300 Victory Boulevard, Suite 600
Woodland Hills, CA 91367-2525
Mailing Address: PO Box 92622
Los Angeles, CA 90009-2622
Claims Phone #: (818) 888-4750

Sacramento DO
2275 Gateway Oaks Drive
Sacramento, CA 95833
Mailing Address: PO Box 254700
Sacramento, CA 95865-4700
Claims Phone #: (916) 924-5100

San Bernardino DO
375 West Hospitality Lane
San Bernardino, CA 92408
Mailing Address: PO Box 1316
San Bernardino, CA 92402
Claims Phone #: (909) 384-4500

San Diego DO
9444 Waples Street
San Diego, CA 92121
Mailing Address: PO Box 85488
San Diego, CA 92186-5488
Claims Phone #: (858) 552-7000

Santa Ana DO
1750 East Fourth Street
Santa Ana, CA 92705
Mailing Address: PO Box 419
Santa Ana, CA 92702
Claims Phone #: (714) 565-5000

Santa Rosa DO
1450 Neotomas Avenue
Santa Rosa, CA 95405
Mailing Address: PO Box 2407
Santa Rosa, CA 95405-0407
Claims Phone #: (707) 573-6500

*There will be one change of note to the State Fund District Office list by the late spring of the year 2000. The claims operations currently located in Monterey Park and Woodland Hills will be relocated at a new facility in Glendale, CA. The post office box mailing address listed will remain the same. The current telephone numbers for the Claims Departments in Monterey Park and Woodland Hills will remain in effect until the move. Telephone calls after that will be forwarded to the new location, or the new telephone number will be given in a voice message.

List of State Compensation Insurance Fund District Offices

Oakland DO
2955 Peralta Oaks Court
Oakland, CA 94605-5398
Mailing Address: PO Box 12971
Oakland, CA 94604-2971
Claims Dept. Phone #: (510) 729-7877

Oxnard DO
2901 North Ventura Road
Oxnard, CA 93030
Mailing Address: PO Box 9045
Oxnard, CA 93031-9045
Claims Dept. Phone #: (805) 988-5300

Redding DO
364 Knollcrest Drive
Redding, CA 96002
Mailing Address: PO Box 496049
Redding, CA 96049-6049
Claims Phone #: (530) 223-7000

Riverside DO
6301 Day Street
Riverside, CA 92507
Mailing Address: PO Box 5025
Riverside, CA 92517-5025
Claims Phone #: (909) 656-8300

San Francisco DO
303 Second Street, Suite 600 South
San Francisco, CA 94107
Mailing Address: PO Box 7455
San Francisco, 94120-7455
Claims Phone #: (415) 974-8200

San Jose DO
6203 San Ignacio Avenue
San Jose, CA 95119
Mailing Address: PO Box 530957
San Jose, CA 95153-5357
Claims Phone #: (408) 363-7400

South Orange County DO
3150 Bristol Street, Suite 400
Costa Mesa, CA 92626-3038
Mailing Address: PO Box 1685
Costa Mesa, CA 92628-1685
Claims Phone #: (714) 668-3400

Stockton DO
3247 W. March Lane
Stockton, CA 95219
Mailing Address: PO Box 8000
Stockton, CA 95208
Claims Phone #: (209) 476-2600

State Contract Services - South
400 Citadel Drive, Suite 100
Commerce, CA 90040
Mailing Address: PO Box 910932
Commerce, CA 90091-1112
Claims Phone #: (323) 727-5600

Riverside State Contract Services
6301 Day Street
Riverside, CA 92507
Mailing Address: PO Box 59901
Riverside, CA 92517
Claims Phone #: (909) 697-7300

Rohnert Park State Contract Services
5900 State Farm Drive, Suite 200
Rohnert Park, CA 94928
Mailing Address: PO Box 1609
Rohnert Park, CA 94927-1609
Claims Phone #: (707) 586-5000

Sacramento State Contract Services
2450 Venture Oaks Drive, Suite 500
Sacramento, CA 95833
Mailing Address: PO Box 659011
Sacramento, CA 95865-9011
Claims Phone #: (916) 567-7500

Government Resources

California State Department of Industrial Relations

Division of Workers' Compensation (DWC)
PO Box 42063
San Francisco, CA 94142
www.dir.ca.gov

Toll-free Information and Assistance Hotline 1-800-573-4636

DWC Information and Assistance District Offices

Anaheim	(714) 738-4038		
Bakersfield	(805) 395-2514	San Bernardino	(909) 383-4522
Eureka	(707) 441-5723	San Diego	(619) 525-4589
Fresno	(209) 445-5355	San Francisco	(415) 557-1954
Grover Beach	(805) 481-3296	San Jose	(408) 277-1292
Long Beach	(562) 590-5240	Santa Ana	(714) 558-4597
Los Angeles	(213) 897-1446	Santa Barbara	(805) 966-9872
Oakland	(510) 286-1358	Santa Monica	(310) 452-1188
Pomona	(909) 623-8568	Santa Rosa	(707) 576-2452
Redding	(916) 225-2047	Stockton	(209) 463-6201
Riverside	(909) 782-4347	Van Nuys	(818) 901-5374
Sacramento	(916) 263-2741	Ventura	(805) 654-4701
Salinas	(408) 443-3058	Walnut Creek	(510) 977-8343

For ongoing information on regulations affecting California Workers' Compensation, ask to be added to Administrative Director's (AD) mailing list. Write to: Administrative Director, Room 5182, at the above address.

Industrial Medical Council (IMC)

PO Box 8888
San Francisco, CA 94128
(650) 737-2767 or 1-800-794-6900 (in California only)
www.dir.ca.gov

The IMC has advisory, policy-making and enforcement jurisdiction over many of the medical aspects of workers' compensation system in California including development of treatment guidelines, physician education and oversight of the Qualified Medical Examiner (QME) program.

California Division of Occupational Safety and Health (Cal/OSHA)

Cal/OSHA Headquarters
455 Golden Gate Avenue
San Francisco, CA 94102
(415) 703-4341

Enforces workplace health and safety regulations in California. Check your local telephone book under "California, State of, Industrial Relations Department, Occupational Safety and Health."

Cal/OSHA also has a **Consultation Service**, which provides free assistance to employers and employee groups to protect workers from accidents and illness on the job.
Phone: (415) 703-4050.

Occupational Health Branch, California Department of Health Services

H. E. S. I. S.
2151 Berkeley Way, Annex 11
Berkeley, CA 94704
(510) 540-2115

Answers questions and provides written materials on workplace health hazards for health care providers, employers, labor unions, and others.

National Institute for Occupational Safety and Health (NIOSH)

4676 Columbia Parkway
Cincinnati, OH 45662
(513) 533-8287
(800) 356-4647

NIOSH, a part of the Centers for Disease Control, is the federal agency responsible for research on occupational injury and illness, and for public health surveillance activities. NIOSH publishes a variety of materials on health and safety issues.

Occupational Safety and Health Administration (OSHA)

US Department of Labor
Occupational Safety and Health Administration (OSHA)
200 Constitution Avenue NW
Washington, DC 20210
(800) 321-OSHA

This agency enforces safety and health regulations for federal employers within California, and provides oversight and partial funding for the state plan (Cal/OSHA). OSHA publishes technical documents and informational pamphlets regarding occupational safety and health and adopts standards.

OSHA Region IX

71 Stevenson Street, Suite 420
San Francisco, CA 94105
(415) 744-6670

The regional office of federal OSHA in San Francisco maintains an occupational safety and health library and can provide a number of resources.

Occupational Health Resources

University-Based Occupational Medicine Clinics

University-based occupational medicine clinics can often provide consultation, diagnosis, and treatment of complex or challenging cases. They provide training in occupational medicine and conduct research on occupational diseases and injuries.

University of California at Los Angeles

Occupational and Environmental Medicine
10911 Weyburn Avenue, Suite 344
Los Angeles, CA 90024
(310) 794-8144

University of California at San Francisco

Occupational and Environmental Medicine Clinic
400 Parnassus Avenue, A585, Box 0322
San Francisco, CA 94143
(415) 476-1841 fax: (415) 502-4223

San Francisco General Hospital (UCSF)
Bldg. 9 Room 109-1001 Potrero Avenue
San Francisco, CA 94110
(415) 206-5391 fax: (415) 206-4157

University of California at Irvine

Occupational Health Center
19722 MacArthur Boulevard
Irvine, CA 92715
(714) 856-8640

University of California at Davis Medical Center

Occupational Safety Center
2315 Stockton Boulevard, Trailer 77
Sacramento, CA 95817
(916) 734-2740

Training and Information

Labor Occupational Health Program - UC Berkeley (LOHP)

University of California
2515 Channing Way
Berkeley, CA 94720
(510) 642-5507

Labor Occupational Safety Health Program - UC Los Angeles (LOSH)

University of California
1001 Gayley Avenue, 2nd Floor
Los Angeles, CA 90024
(310) 794-5964

Provides training sessions, technical assistance, publications, and videos on health and safety issues for employees and employers.

Continuing Professional Education

Northern California Educational Resource Center (ERC)

Northern California Center for Occupational and Environmental Health, Continuing Education
University of California at Berkeley, Richmond Field Station
1301 South 46th Street, Building 102
Richmond, CA 94804
(510) 231-5645 fax: (510) 231-5648

Southern California Educational Resource Center (ERC)

University of Southern California Institute of Safety and Systems Management
Professional Programs
927 West 35th Place, Room 102
Los Angeles, CA 90089-0021
(213) 740-3995 fax: (213) 740-8789

ERCs conduct research on occupational illnesses and injuries and offer degree programs and continuing education courses related to health and safety.

Committees for Occupational Safety and Health (COSH)

COSH groups are organizations of occupational health professionals, labor unions, workers, and community activists. The COSH groups listed below maintain resource libraries on various occupational health issues. They can also provide injured workers with referrals and information regarding support groups in their areas.

LACOSH
5855 Venice Boulevard
Los Angeles, CA 90019
(213) 931-9000

SCCOSH
760 N. First Street, Second Floor
San Jose, CA 95112
(408) 998-4050

SACOSH (Sacramento)
3101 Stockton Boulevard
Sacramento, CA 95820
(916) 442-4390

Professional Organizations

American College of Occupational and Environmental Medicine (ACOEM)

55 West Seegers Road
Arlington Heights, IL 60005
(847) 818-1800

American Public Health Association (APHA)

Occupational Health Section
1015 Fifteenth Street, NW
Washington, DC 20005
(202) 789-5600

California Chiropractic Association

7801 Folsom Boulevard, Suite 375
Sacramento, CA 95826
(916) 387-0177

California Society of Industrial Medicine and Surgery (CSIMS)

1000 Q Street
Sacramento, CA 95814-6518
(916) 446-4199

Western Occupational Medicine Association (WOMA)

50 First Street, Suite 310

San Francisco, CA 94105
(415) 764-4803

Printed Materials

Useful Peer-reviewed Journals

American Journal of Industrial Medicine

The Back Letter

British Journal of Industrial Medicine

Journal of Occupational Medicine

Occupational Medicine: State of the Art

Scandinavian Journal of Work, Environment and Health

Labor Code and Regulations

California Labor Code (Parker & Son Publications, Inc.) PO Box 9040, Carlsbad, CA 92018

Workers' Compensation Laws of California, Oakland: Matthew Bender & Co. Inc., yearly edition, (2101 Webster Street, Oakland, CA 94612). For information on ordering, call 1-800-833-9844.

The California Code of Regulations, Barclays Law Publishers, 50 California Street, San Francisco, CA 94111

Fee Schedule

To order the Official California Workers' Compensation Medical Fee Schedule (covers treatment fees); call 1-800-765-6023 or write to DWC, Dept. 05445, PO Box 39000, San Francisco, CA 94139-5445.

Reference Books and Articles

ACOEM Position on the Confidentiality of Medical Information in the workplace. JOEM 37(s): 594-596, 1995.

Akabas Sheila H., Gates, Lauren B. and Galvin, Donald E. *Disability Management: A Complete System to Reduce Costs, Increase Productivity, Meet Employee Needs and Ensure Legal Compliance.* New York: American Management Association, 1992.

Americans With Disability Handbook published by the Equal Employment Opportunity Commission and the US Department of Justice (EEEOC-BK-19).

American Medical Association. *Guide to the Evaluation of Permanent Impairment*, 4th ed. Chicago: American Medical Association, 1993. (Order Dept. PO Box 10946,
Chicago, IL 60610.

California Compensation Cases is published monthly by Matthew Bender & Co. ($215 per year): (800) 833-9844. The CCC reports all WCAB *en banc* and selected decisions or related interest.

Herington TN and Morse LH. (1994). Occupational Injury. St. Louis, MO: Mosby Yearbook.

Herlick, Stanford, Workers' Compensation Handbook, 14th ed. 1994 (Butterworth Legal Publ.)

Industrial Medical Council. Medical Practice in the California Workers' Compensation System - Physician's Guide 2nd Edition 1997. San Francisco, CA: Industrial Medical Council, Dept. of Industrial Relations, State of California. See order form at the end of this appendix.

LaDou, J., ed. *Occupational Medicine*. Norwalk: Appleton & Lange, 1990.

O'Brien, David; O'Brien, Bernadette Egglestrom; Workers' Compensation Claims & Benefits, 11th ed., 2000. To order call (909) 585-7101).

Occupational Medicine: State of the Art Reviews. Philadelphia: Hanley & Belfus, Inc. (210 S. 13th St., Philadelphia, PA 19107).

Rom, W.N., ed. *Environmental and Occupational Medicine*, 2nd ed. Boston: Little, Brown, 1992.

St. Clair, Sheldon C. *California Workers' Compensation Law and Practice*, 5th ed. Van Nuys: California Compensation Seminars. (To order the book and periodic supplements call (818) 349-7853.)

Stewart, James T.: *Work Comp. Index*: 4th ed: 1937 Santa Ana, Clovis, CA 93611.

Thurber, Packard. *Evaluation of Industrial Disability*, 2nd ed. Oxford University Press: New York, 1960.

Wallerstein, Nina and Rubenstein, Harriet L. *Teaching About Job Hazards: A Guide for Workers and Their Health Providers.* Washington, DC: American Public Health Association, 1993.

Zenz, C. *Fundamentals of Occupational and Environmental Medicine*, 3rd ed. Chicago: Year Book Medical Publishers, 1994.

Newsletters/Periodicals

Bureau of National Affairs. *Workers' Compensation Report* (biweekly). Available from: BNA, 1231 25th NW, Washington, DC 20037. ($512/year). National workers' compensation reporting service. Another useful BNA publication specific to California is *BNA California Employee Relations Report,* Which covers workers' compensation and other benefits issues.

Burton, John. John Burton's *Workers' Compensation Monitor* (bi-monthly). Available from: LRP Publications, 747 Dresher Rd., PO Box 960, Horsham, PA 19044-0980. ($160/year).

California Workers' Comp Advisor, (monthly). Available from: Genesis Publishing, Inc., 10455 Sorrento Valley Road, Suite 103, San Diego, CA 92121; 800-632-0123; $247 per yr.

California Workers' Compensation Enquirer (monthly). Available from: C.W.C.E. Publications, PO Box 5460, Los Alamitos, CA 90721-5460. Phone (310) 430-8707. ISSN# 0883-9867. ($65/yr., or $100/two yrs.).

California Workers' Compensation Reporter, (monthly). Available from: California Workers' Compensation Reporter, PO Box 975 Berkeley, CA 94701. Phone (510) 444-2454. ($300/year). This newsletter provides articles on legal perspective, case laws, and policy issues.

DWC Newline, the Newsletter of the Division of Workers' Compensation (415) 975-0700.

Medically Speaking, the Newsletter of the Industrial Medical Council, call (650) 737-2767 or 1-800-794-6900 (in California only) to be placed on the mailing list. Copies are free.

Websites Of Interest

Government Agencies

Agency for Health Care Policy and Research (AHCPR)	www.ahcpr.gov
CA Medical Board	www.docboard.org/ca/df/casesearch.htm
U.S. Center for Disease Control and Prevention (CDC)	www.cdc.gov/
CA Div of Workers' Compensation (DWC)	www.dir.ca.gov
Federal Drug Administration (FDA)	www.fda.gov
National Institutes of Health (NIH)	www.nih.gov

Professional Organizations

Am Association of Oriental Medicine	www.aaom.org/aahome.htm
American Chiropractic Association	www.cais.net/aca/
American College of Occupational and Environmental Medicine (ACOEM)	www.acoem.org
Am Col. Of Physicians	www.acponline.org/
American Medical Association	www.ama-assn.org
Am Osteopath Association	www.am-0steo-assn.org/
Ca Chapter of the Am Physical Therapy Association	www.ccapta.org
California Chiropractic Association	www.calchiroassn.org
California Medical Association	www.cmanet.org
Western Occupational & Environmental Medicine Assoc. (WOEMA)	www. woema.com

Medical Literature Database

Medscape	www.medscape.com/
National Library of Medicine	www.nlm.gov/ www.igm.nlm.nih.gov/ www.ncbi.nlm.nih.gov/PubMed/
MedWeb: Electronic Publications	www.gen.emory.edu/MEDWEB/keyword/electronic_publications.html
MedWebPlus	www.medwebplus.com/

Clinical Guidelines by Diagnosis

American College of Occupational and Environmental Medicine(ACOEM)	www.acoem.org
CA Industrial Medical Council	www.dir.ca.gov

Clinical Treatment Guidelines (also see Professional Organizations)

Am Academy of Allergy, Asthma and Immunology (AAAAI)	www.AAAAI.org
Am Association of Electrodiagnostic Medicine	www.pitt.edu/~nab4/aaem.html www.aaem@aaem.net
American Acad of Pain Medicine(AAPM)	www.painmed.org/
Am Society of Anesthesiologists (ASA)	www.asahq.org

Clinical Information

Am Col. Physicians Journal Club	www.acponline.org
The Cochrane Database of Systematic Reviews	www.hcn.net.au/cochrane/
GenX (drug info)	www.mosby.com
mediconsult	www.mediconsult.com
Medscape	www.medscape.com
Pharmaceutical Info Network	http://pharminfo.com/pin_hp.html
The Internet Drug Index	www.rxlist.com

APPENDIX E

The Industrial Medical Council's Study

and

ERTW Policy

APPENDIX E

The Industrial Medical Council's Study and ERTW Policy

The IMC conducted a comprehensive literature review of peer reviewed studies on the impact of modified work after an industrial injury (Krause, N., IMC Study, 1997). The review indicates that an early return to the fullest activity level as is medically appropriate and feasible reduces deconditioning and adverse psychological reaction to injury, and improves the likelihood of a sustained return to the injured employee's pre-injury activity and productivity level.

As a result of this study, which substantiated the benefits to the injured employee and the employer, the Industrial Medical Council developed a policy statement in favor of early return to work and adopted this policy statement in September, 1998:

> **An injured worker should return to work as soon as it is medically feasible. If the injured worker is unable to immediately engage in his/her usual occupation, the injured worker should be returned to modified or alternative work, provided that the work can be practically accommodated by the employer. The treating or evaluating physician should recommend appropriate and specific work restrictions.**

Recommendations from the IMC for implementation include:

1. Physicians assess and communicate specific work restrictions to allow for the return-to-work appropriate to each injured employee's condition, as soon as possible following an industrial injury;
2. Employers determine the options for modified/alternative work which are feasible in view of the injured employee's restrictions and his/her usual work duties; and
3. Collaborative communication among injured employees, employers, the treating or evaluating physicians, insurers, case managers, and vocational rehabilitation counselor be maintained to achieve an appropriate and sustained return to work after an industrial injury.

APPENDIX F

Post Test

Evaluation

The California Workers' Compensation System
A Manual for the Treating Physician
revised 1999

Post Test

Please use the answer sheet to respond to the following post-test questions:

1. Which of the following describe Medical Benefits to be provided under the California Workers Compensation System:

a. Medical treatment reasonably required to cure or relieve the injured employee from the effects of the illness/injury but only as long as the injured is an employee of the particular business where the injury occurred.
b. Medical treatment that is reasonably required to cure or relieve from the effects of the illness or injury.
c. Medical treatment reasonably required as determined by the cost of the cure to relieve the injured worker from the effects of the illness or injury.
d. None of the above.

2. In addition to medical treatments reasonably required to cure or relieve the effects of an industrial injury, the following are benefits potentially available to an injured worker depending on the severity of the injury or illness:

a. Temporary Partial or Temporary Total Disability payments also known as "lost wages".
b. Permanent Partial or Permanent Total Disability payments.
c. Vocational Rehabilitation Benefits.
d. Death Benefits
e. All of the above.

3. The Primary Treating Physician (PTP), as defined in California Code of Regulations (CCR 9785) is:

a. The physician who provides the Permanent and Stationary (P&S) Report.
b. The physician who is primarily responsible for managing the care of an injured employee, who has examined the employee at least once for the purpose of rendering or prescribing treatment, and who has monitored the effect of the employee's treatment thereafter.
c. Always the first physician to treat an injury immediately after occurrence.
d. The employee's personal physician whether or not that physician is treating the injured's work-related injury.

4. The Primary Treating Physician in the Workers' Compensation system is responsible for which of the following?

a. Determining medical causation.
b. Determining medical eligibility for vocational rehabilitation services.
c. Determining when the injured employee's condition is Permanent and Stationary.
d. All of the above.

5. Once an initial working diagnosis is established, the physician will next make a reasoned judgment as to the injury's:

a. permanent and stationary status.
b. work relatedness (AOE/COE).
c. impairment factors.
d. severity to determine medical eligibility for vocational rehabilitation.

6. In workers' compensation the restoration of function and return to work is the primary treatment objective because:

a. The literature indicates that the longer an employee is away from the work site, the less likely the chance of a successful return to work.
b. When return to work is delayed, psychological factors may interfere with recovery.
c. Prolonged rest will cause deconditioning, which impedes further healing and may predispose the worker to chronic symptoms.
d. All of the above.

7. The return to work before 100% recovery through appropriate transitional duty is an effective treatment tool in the process of:

a. doing what the payor asks.
b. doing what the employer asks.
c. returning the injured employee to full employment and avoiding delayed recovery.
d. doing what the employee asks.

8. The primary treating physician's role in returning the employee to transitional duty involves interaction with:

a. the injured employee only.
b. the employer/supervisor only.
c. the payor only.
d. injured employee, the employer/supervisor and the case manager/claims adjuster
e. in a collaborative link.

9. To guide appropriate transitional work assignments, the work restrictions will be written in response to:

a. functional limitations of the injured employee, that is: the capacity and duration per day for physical and mental activity tolerated while continuing to heal.
b. the physician's desire to be viewed as the bountiful giver of all requests.
c. evaluation of the healing at specified intervals.
d. a and c.

10. Written work restrictions are most easily conveyed to the employer/supervisor when they are:

a. in global terms
b. specific and measurable
c. in the functional terminology used in job descriptions.
d. b. and c.

11. The California Utilization Review Regulation is a code of conduct about obtaining and giving authorization for payment before the treatment occurs and the regulation:

a. insures that a medically reasoned opinion by a peer is behind any denial for authorization by a payor and that the written opinion is available on request.
b. encourages providers to have reasoned medical opinions to support treatment planning.
c. is a form of bill review.
d. is meant to harass the physician.
e. a and b.

12. A request for authorization for payment on a proposed treatment plan:

a. must be given in writing in a standardized format, can be sent by facsimile, electronic mail or surface mail.
b. can be a telephone request to the claims administrator.

13. The Doctor's First Report of Injury contains key information including how, when, where the injury occurred, the specific diagnosis, findings,

a. Treatment provided;
b. Treatment plan;
c. Work restrictions;
d. anticipated return to work date.
e. All of the above.

14. If the employee or the employer asks the physician not to file a Doctor's First Report (DFR), the physician may comply with this request.

a. False. It is illegal for a physician to avoid filing the DFR if he or she believes the injury to be work related, even if only First Aid is delivered.
b. True.

15. In California, a Doctor's First Report of Occupational Injury/Illness must be filed by the treating physician after the initial evaluation of a patient with an occupational injury or illness:

a. Within the day of exam.
b. Within 5 days.
c. Within 7 days.
d. Only after the diagnosis of an occupational injury/illness has been absolutely established.

16. In California, Progress Reports in a standardized format to the payor are required at least every

a. 12 visits
b. 12 weeks
c. 45 days
d. week

17. When an injured worker has reached Permanent and Stationary (P&S) status, the injured worker:

a. is no longer considered temporarily disabled.
b. may still be in need of future medical treatment.
c. is designated a qualified injured worker.
d. is also considered permanently, totally disabled.
e. All of the above
f. a, b only.

18. In the California Worker's Compensation system, impairment differs from disability in that:

a. It is a medical determination which follows a Disability Rating.
b. It is made by a non-medical professional.
c. It is a medical determination of the injured employee's anatomic or physiologic loss.
d. It is based only on objective factors.

19. The factors of disability needed by a Disability Rating Specialist to decide a rating on an injured worker will include the medical impairment determination and includes which items?

a. Objective and subjective medical factors.
b. Work restrictions.
c. Loss of pre-injury capacity.
d. All of the above.
e. None of the above.

20. Medical Eligibility for vocational rehabilitation services is determined by the Primary Treating Physician and is best described as:

a. The injured employee's right to obtain medical care for a work related injury.
b. The obligation of the injured employee's group medical insurance to provide medical care.
c. The minimum time on the job required to be covered under the employer's workers' compensation policy.
d. The expectation that the injured worker will have permanent residual disability as a result of the injury that precludes or is likely to preclude return to his/her usual and customary occupation or the job at the time of injury and therefore may be eligible for vocational rehabilitation benefits.

21. An injured worker will have Qualified Injured Worker (QIW) status, that is, the injured employee is a candidate for vocational rehabilitation benefits when which two criteria are fulfilled:

a. The worker is declared permanent and stationary (P&S) and wants to do a different job.
b. The worker has achieved a P&S status and vocational feasibility exists.
c. The worker has achieved P&S status and is medically eligible.
d. The worker is medically eligible and vocational feasibility exists.

22. The goal of Vocational Rehabilitation is to enable an injured worker who is permanently disabled as a result of the injury to return to:

a. work under any conditions.
b. school to learn the occupation s/he always wanted to whether or not s/he has the abilities.
c. suitable, gainful employment.
d. none of the above.

23. Which of the following are among the most frequently disputed issues in workers' compensation that involve the opinion of the treating physician:

a. The best occupation for a qualified injured worker.
b. Medical causation.
c. Nature and extent of permanent disability
d. Apportionment.
e. b, c, d only.

24. Comprehensive medical-legal reports are required only in the case of a disputed medical issue and must be capable of proving or disproving a disputed medical issue such as:

a. An employee's medical condition (diagnosis).
b. The cause of the employee's medical condition, that is, whether it arose out of and in the course of employment (AOE/COE).
c. The permanent disability caused by the employee's medical condition.
d. The employee's ability or inability to return to the pre-injury occupation (medical eligibility for vocational rehabilitation).
e. All of the above.

25. Which of the following best describes a comprehensive medical-legal report:

a. It must be written on a form from the Division of Workers Compensation.
b. It should contain sufficient information to allow a determination of the necessity for current/future medical treatment, vocational rehabilitation benefits, and the level of permanent disability.
c. The conclusions contained in the report should be based on medical possibility, rather than reasonable medical probability.
d. It should be written in the language required for acceptance for publication in a peer reviewed journal.

STATE COMPENSATION INSURANCE FUND

CALIFORNIA MEDICAL ASSOCIATION ACCREDITED CONTINUING MEDICAL EDUCATION

A Manual for the Treating Physician
revised 1999
Answer Sheet

Please print or type the following information: **SCIF PPN _____Yes _____ No**

Name: _____Specialty:_____

Address: _____
_____

Medical License Number: _____Today's Date:_____

Signature_____

Please complete the following by circling the correct answer:

1. a b c d	6. a b c d	11. a b c d e	16. a b c d	20. a b c d	24. a b c d e
2. a b c d e	7. a b c d	12. a b	17. a b c d e f	21. a b c d	25. a b c d
3. a b c d	8. a b c d	13. a b c d e	18. a b c d	22. a b c d	
4. a b c d	9. a b c d	14. a b	19. a b c d e	23. a b c d e	
5. a b c d	10. a b c d	15. a b c d			

This is an activity offered by State Compensation Insurance Fund, a CMA-accredited provider. Physicians participating in that course may report up to four hours of Category 1 credit toward the California Medical Association's Certificate in Continuing Medical Education (CEU) and the American Medical Association's Physician's Recognition Award. Six credits of Qualified Medical Examiner CEU's have been approved by the California Industrial Medical Council for this self-study course.

_____

_____

_____

_____

Medical Director' Office
Continuing Medical Education
State Compensation Insurance Fund
1275 Market Street Suite 1400
San Francisco, Ca 94103

STATE COMPENSATION INSURANCE FUND

The California Workers' Compensation System
A Manual for the Treating Physician
revised 1999
Evaluation

This manual has been developed to assist primary treating physicians caring for California workers injured on the job. Please assist us in evaluating the content and usefulness of this information in you practice by answering the following questions:

1. What portion of your practice may involve treatment of injured workers in the workers' compensation system? _____%

2. How much of the content of this manual was new information for you? _____%

3. Please list the 3 chapters that you feel will be most helpful to you in your practice:

   a. _____

   b. _____

   c. _____

4. Please list the 3 chapters that are least helpful and why:

   a. _____

   b. _____

   c. _____

5. Would you recommend this manual to another treating physician? ____ Yes ____ No

6. Your suggestions for improvement:

   _____

   _____

   _____

   _____

Thank you for your assistance.

Please fold this page and your answer sheet in half with the mailing address showing and apply the correct amount of postage. A certificate for 4 hours of CME CME Category I credit and 6 hours of IMC QME credit will be forwarded to you.

This is an activity offered by State Compensation Insurance Fund, a CMS-accredited provider. Physicians attending this course may report up to four hours of Category 1 credit toward the California Medical Association's Certificate in Continuing Medical Education and the American Medical Association's Physician's Recognition Award.