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HOW TO WORK WITH YOUR WORKERS' COMPENSATION CARRIER FOR THE BEST OUTCOMES

By Corey Ingber

THE FIRST 90 DAYS FOLLOWING FILING OF CLAIM FORM (DWC-1)

- **COMPENSABLE INJURIES vs. FIRST AID ONLY:** Compensable industrial injuries are those which result either in lost time beyond the employee's work shift at the time of injury or in the furnishing of medical treatment beyond first aid.[i]

- **COMPENSABLE INJURIES TRIGGER PROCESS TO INVESTIGATE**: Except for first aid only injuries, all other "injuries" are potentially compensable and following the filing of the Claim Form with the Employer, the carrier has 90 days within which to investigate the claim and therefore either admit or deny that claim within this period.

- **DUTY TO PROVIDE CLAIM FORM AND NOTICE OF BENEFITS TO EMPLOYEE**: Employee's Claim for Workers' Compensation Benefits ("Employee Claim Form" DWC-1) to be provided to Employee, together with Notice of Potential Eligibility either personally or by first class mail, within one working day of receiving notice or knowledge of injury.[ii] This Employer "knowledge" may arise from any source, on the part of the Employer, Managing Agent, and Superintendent, Foreman or other person in authority. The standard is whether the knowledge is sufficient to afford an investigation. [Labor Code 5402(a)]. In addition, the Employer is required to furnish a Notice of Benefits to the Employee.

- **EMPLOYEE FILES DWC-1 WITH EMPLOYER**: The Employee Claim Form (DWC-1) is "filed" with the Employer either on the date of actual personal service or upon the date of receipt either by first class or certified mail. [1] The obligation to provide benefits does not depend upon the Claim Form being filed with the Employer.[2]

[1] Labor Code 5401(a)
[2] 8 CCR 10137

- **THE 90 DAYS TO INVESTIGATE BEGINS:** From the date of the filing of the Claim Form, the Employer has 90 days within which to reject the claim, otherwise the claim becomes presumptively compensable and rebuttal evidence is then expressly limited only to that evidence which was not discoverable or obtainable during the 90 day period.[iii] In effect, a late denial means the Employer essentially is left in the position of having to disprove the Employee's claim, but limited only to evidence which could not have otherwise been obtained *during* the 90 day period.

- **MEDICAL TREATMENT MUST BE PROVIDED DURING THE DELAY PERIOD:** In order to encourage prompt investigations, SB 899 initiated changes to Labor Code 5402 by adding sub-section (c), which contains a provision by which the Employer must authorize the provision of all medical treatment, consistent with evidence based medicine protocols, within 1 working day after the employee files the Claim Form, up until the time the claim is either accepted or rejected. The treatment during this period has a cap of $10,000.

- In many instances, the carrier will issue a "delay" decision, informing the injured worker when they will make their final decision on compensability and will then authorize medical treatment consistent with these provisions, while they conduct their investigation. The Notice of Benefits specifies the claim is on "delay" and that TD is not being paid.

- This is the critical "first 90 day period," where Employers need to be vigilant and proactive. This is a time when evidence needs to be secured, witnesses established and investigations conducted. You cannot afford to "sit on the evidence." For example, in **Williams v. WCA**B, the Court held that the defendant could not use the testimony from witnesses it knew of in denial of the claim, when during the 90 days; it accepted the claim and otherwise chose to ignore those witnesses. Investigations should initiate promptly.

THE IMPORTANCE OF EARLY REPORTING OF A CLAIM AND PROMPT INVESTIGATION

- **INJURIES COME IN ALL SHAPES AND SIZES**: An industrial injury can be a *specific event* or trauma, including an accident, a slip or trip and fall, motor vehicle collision, assault, falling objects, defective machinery, tools and devices, a lifting, pulling or carrying incident, contact with objects, exposures to harm producing elements at work, such as a gas leak or chemical spill, or even a simple bodily movement, provided it was caused/aggravated by some incident of the work place. An injury can also result from an industrial aggravation of a pre-existing

condition, whether congenital, chronic or simply a quiescent pathology. For example, an Employee could have Type II Diabetes, which is under good control and maintenance, but following a slip and fall injury at work, and a surgical repair to the right knee, the diabetes has flared and the Primary Treating Physician has determined there is an aggravation either by the injury or as a result of the ensuing surgical procedure. An injury can also result from *cumulative or repetitive trauma*, most often featuring claims of injury to the employee's **psyche and internal system**, in addition to claims of occupational illness and disease (asbestos, long term inhalation to carcinogens or harmful airborne gasses or particles). Psychiatric injuries are specifically recognized in the Labor Code and they can arise either from a specific injury, cumulative trauma or possibly both.[iv]

- **EMPLOYER OBLIGATION: EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS (5020):** All Employers are required to file a Form No.: 5020, Report of Occupational Injury or Occupational Illness, whenever the injury results in lost time *beyond the date of the injury* or illness or which requires medical treatment beyond first aid.[v] An insured Employer files this report with the insurer within 5 days after Employer obtains knowledge of the injury or illness. [Lost time here means absence of work for a full day or shift beyond the date of injury. While this may be overly technical, it seems as if the Claim Form must be given to the Employee when he or she loses time beyond the work shift on the date of the injury. So, if an Employee works a 7 hour shift on the date of injury, and comes in 4 hours into the next day shift, the Claim Form is required. But, unless the employee loses the entire next day shift, the 5020 would not be required. The self-insured Employer files the form electronically with the Administrative Director of the DWC. (Serious injuries, illness or death are also reportable to Cal OSHA immediately by telephone or telegraph. There is a $5,000 civil fine (penalty) for violations of this section. [Labor Code 6409.1].

- **THE CRITICAL IMPORTANCE OF EARLY REPORTING**: You should immediately contact your administrator or workers' compensation carrier and provide them with information regarding the claim, either of which you have notice or by which you have been officially served with the Claim Form (above). *This is the critical time when the investigation should occur. [1] Was the injury reported promptly on the date thereof or the next day; or was this a later reported injury, perhaps after a three day weekend or legal holiday? [2] Was the injury witnessed and if so and by whom? [3] Was the Employee offered medical treatment? Did he or she accept or decline the offer? [4] Is the injury documented? What is the date and time? [5] When did the employee first obtain medical treatment? [5] Was the work shift completed? [6]] Did the Employee return to work the next day? [7] If not when [8] If the Employee returned to work, were there temporary restrictions or was the worker released back to full duty?* It is critical that the claims administrator or carrier be afforded this information as soon as possible, so that they can set up their claim and formally initiate the claims handling and notification process, mandated by the Labor Code and governed by regulations.

- **THE INSURER NOTIFIES EMPLOYER OF CLAIM FILED DIRECTLY**: Insurer is required to notify Employer within 15 days of each claim for indemnity filed against Employer directly with the insurer if the Employer has not provided to the insurer the Report of Occupational Injury or Occupational Illness.

- **COMMUNICATION WITH ADMINSTRATOR OR CARRIER**: You need to be aware that communications with the administrator or carrier is important at this early stage. Information about the claim of injury is essential. If the incident or injury was witnessed or reported promptly and there are no reasonable suspicions or so-called "red flags," then you should inform the carrier so they can make a good decision to accept the claim. Accepting the claim means that under most circumstances, *they will get to control the medical treatment within the Medical Provider Network (MPN).* Prompt attention here to good communications can enhance the decision making process, expedite the provision of benefits and in some cases, the Employee might be less inclined to hire an attorney, if he/she is receiving good medical care and promptly furnished benefits. A late reported claim to the administrator or carrier can often lead to employee frustration and animosity, and increased litigation if the worker is not receiving any benefits so the inclination is to go out and hire an attorney.

- **EVIDENCE DISCOVERED EARLIER IS BENEFICIAL**: If you are privy to information which would tend to impact the claim decision process, then you need to provide this to your administrator or carrier. This might often include "hearsay" or even "rumors" which could form the later basis for further inquiry or investigation. For example, you have a short-term Employee, who is known to brag about his many "prize fights" outside of work. You have seen him come to work with swollen lips, black eyes and bruises. He reports an injury to his arm and from every indication it was promptly reported with medical treatment obtained that day. However, it is the same arm which you observed had been bruised and bandaged only a month before. You need to inform your carrier, so they can investigate this. Even if you have a compensable injury, the presence of "other factors" could lead to another explanation for the injury or perhaps form a basis for establishing apportionment for permanent disability.

- **TIME IS CRITICAL**: Evidence can become lost or obscured. Employees could separate from the company or memories may simply fade over time. It is very strongly recommended that suspicions or "red flags" be communicated early to your administrator or carrier. Remember, they might accept the claim before the running of the 90th day, especially when they are provided no information to the contrary. Be sure to provide all information available, so they can make a well informed decision.

THE PRESENCE OF "RED FLAGS"

This list is neither intended to be complete nor in any way exhaustive. It simply illustrates some potential "red flags" which might be commonly associated with a claim being made under suspicious circumstances: No one "red flag" alone should automatically serve as a disqualifier but several "red flags" may signal something much more serious.

- An injury without a witness
- The Employee claims he/she reported the injury, but this is disputed by Employer
- Inconsistent statements from Employee supporting claim
- The facts presented to the Employer are different from the facts reflected in the Employee Claim Form (DWC-1)
- Claim Form contains body parts which were not part of the original injury report
- Employee refuses to provide information about the claim to the Employer
- Statements from co-workers questioning claim
- Late reported claim: *"It happened on Friday…..reported on Monday"*
- Claim is reported the day after a holiday or vacation
- Reported injury –Employee states he/she is "fine" and declines medical treatment
- History of disciplinary problems before reporting of injury
- Employee history of threatening or harassing other workers
- History of temper and abusive behavior
- Personnel records document substantial missed time prior to injury

- Employer questions injury occurring within course of employment
- Known prior disabilities
- Time and place of injury are suspicious
- Employee under personal improvement plan
- Employee under final warning or suspension
- Employee had notice of layoff or termination prior to injury
- Claim filed after layoff or termination of employment
- Employee claims injury while leaving facility following termination
- Employee quit without notice
- Short term Employee
- Part time Employee with known concurrent employment
- Employee made pre and/or post injury comments to co-workers, raising suspicions
- Employee threatened attorney action before reporting injury
- Suspected drug use
- History of grudges against Employer
- Witness think Employee was faking injury

EMPLOYER CLAIMS DOCUMENTATION

- **EMPLOYER'S FIRST REPORT OF INJURY**: Form 5020: This is not an admission of liability nor is it admissible evidence. It should be completed as soon as possible. It is often good information for the defense attorney in preparing the initial opinion and case evaluation.

- **EMPLOYER LEVEL INVESTIGATION**: Was the injury reported timely and was the Employer made aware of the injury either directly through the Employee or indirectly through notice by another Employee, including Supervisor? Was the injury reported that day or at some other time?

- **EMPLOYER'S OWN INJURY REPORTING SYSTEM**: Were the reports and supporting paper work undertaken?

- **PROVISION OF CLAIM FORM TO EMPLOYEE**: Proof or confirmation that Employee was provided a Claim Form within 1 working day of receiving notice or knowledge of an injury beyond first aid or time lost beyond the Employee's work shift, pursuant to Labor Code 5401.

- **EMPLOYEE SERVES CLAIM FORM ON EMPLOYER**: Proof of receipt, including certified mail receipt or personal service.

- **WAGE STATEMENT**: This will help the carrier establish the proper average weekly earnings, so that we avoid collateral issues over proper amounts for TD and PD.

- **PERSONNEL RECORDS:** These should be available and you should expect a request for records, whenever the carrier receives notice of a psychiatric injury. Personnel records are extremely important in defending psyche based claims. They are often also sought by the Employee's counsel.

INFORMATION TO WHICH EMPLOYER IS ENTITLED

- **15 DAY CLAIM NOTIFICATION FROM CARRIER**: Insurance carrier to inform Employer of each claim for indemnity filed directly with insurer, within 15 days, if Employer has not previously provided the carrier with the Employers First Report of Injury. [Labor Code 3761(a)]. The carrier then provides the insured Employer with an opportunity to provide all relevant information prior to the expiration of the 90 day period, available to the Employer concerning this claim.

- **EMPLOYER'S "BILL OF RIGHTS":** The insured Employer has limited access to information relating to the claim insofar as it affects premium. [Labor Code 3762(a), (b) and (c).

- **TO WHAT INFORMATION IS THE INSURED EMPLOYER ENTITLED?** The insured employer is entitled to limited claims information from the carrier. This is based upon the essential privacy entitlement accorded to medical records of the Employee, even though the HIPPA laws do not formally apply to workers' compensation. Still, there are privacy laws which are in the California Civil Code, so there is a limited right to privacy here and medical records and information to which the Employer may be entitled is therefore limited under the Labor Code. Set forth below are the most commonly sought after items, and my take on what is allowable and what may not be:

ITEM SOUGHT	EMPLOYER ENTITLED?	NOT ENTITLED?
Employee Notices	Yes	
Notice of Delay	Yes	
Notice of Benefits	Yes	
Notice of Denial	Yes	
Print out of Benefits Paid	Yes	
Reserve Sheets	Yes	
Reserves: estimated treatment, medical-legal, vocational rehabilitation and all other expenses on the claim;	Yes	
Reserve Changes	Yes	
Reserving Rationale	Yes	
Loss Runs	Yes	
Notice of SJDB	Yes	
Offers of Work	Yes	
MEDICAL:		
--Diagnosis of the physical condition for which workers' compensation benefits are being claimed	Yes	
--Diagnosis of the mental		

condition for which workers' compensation benefits are being claimed;	Yes	
--Treatment physical	Yes	
--Treatment mental	Yes	
Actual Medical Reports		No
Sufficient to allow Employer to modify work duties, so this means work restrictions, wither temporary or permanent together with work function and functional capacity evaluations	Yes	
Investigative Reports		No-if attorney requested
Sub-rosa films	Yes	No-if attorney requested
Letters from defense counsel discussing case exposure, opinion, investigation, or other thoughts and opinions from counsel		No
Letters from counsel objecting to treatment charges or other billings	Yes	
Settlement Documents	Yes	
ISO Index	Yes	
Liens, including EDD	Yes	
Claim Notes from Examiner	Yes but limited— To	

	the extent they affect the premium and provided they do not disclosure prohibited medical information and otherwise privileged communications to and from counsel	

RIGHT OF EMPLOYER TO OBJECT TO A SETTLEMENT AND AVAILABLE REMEDY

- **EMPLOYER MAY NOTIFIY CARRIER AT ANY TIME WHERE THERE ARE FACTS WHICH WOULD TEND TO DISPROVE ANY ASPECT OF THE CLAIM**: Employer shall notify the insurer in writing any time during the pendency of the claim when there is actual knowledge of any facts which would tend to disprove *any aspect of the claim.*[vi]

- **EMPLOYER NOTIFIES CARRIER THAT NO COMPENSABLE SHOULD BE PAYABLE:** When the Employer provides a written notice to the carrier that in its opinion, no compensation is payable then upon notification to the WCAB, an agreement to settle the claim either by compromise and release or stipulated findings and award may still issue, *but only upon proof of service upon the Employer not less than 15 days prior to the Appeals Board action, of notice of the time and place of the hearing at which the compromise and release agreement or stipulated findings and award is to be approved. (Or the same time frame where there is no hearing but a scheduled "walk thru" to the WCAB for approval would seem to trigger the same afforded notice to the Employer).* Insurer to file proof of service upon the Appeals Board demonstrating that proof of service of the notice was made to upon the Employer at its last known address.[vii] If the required "notice is not provided," this does not prevent approval of the settlement, but the WCAB may order costs against the insurer, which can include reasonable attorney fees.[viii]

- **EMPLOYER CHALLENGES SETTLEMENT:** Under Labor Code 3761(d) when the Employer challenges the settlement, but the carrier proceeds to settle the matter notwithstanding, then if post-settlement, the WCAB determines in a finding that no compensable is payable under Division 4 of the Labor Code, then ***the insurer shall reimburse the Employer for any premium paid solely due to the inclusion of the successfully challenged payments in the calculation of the Employers' experience modification.*** EXAMPLE: Archie Achilles, a 48 year old truck driver, is employed by Gotta-Run Services, as a full time driver. He sustains an admitted back injury and is off of work 6 months while Famous Insurance Co. administers benefits. During the 5th month of TD, the Foreman, Nancy Watching, sees Mr. Achilles, driving a truck for ZYX Trucking. She calls the Examiner at Famous, but the examiner loses the notes and forgets to input the information, so that no investigation is done on the applicant working and receiving TD at the same time. Benefits are extended another year. 18 months later, the applicant and Famous settle the case by stipulated findings and award, including 15 months of TD. Gotta-Run objects to the settlement, claiming that Archie had worked full time for 10 months and that they should get credit for the 10 months (40 weeks) of payments at $900.00 per week, or $36,000. The matter is settled but set for hearing. Counsel for Gotta-Run subpoenas the employment records from ZYX and calls a supervisor for that employer to trial, in additional to introducing the Print out of Benefits from Famous, demonstrating the concurrent receipt of both TD and wages. The WCAB finds in favor of Gotta-Run. Here, the carrier will have to credit premium against the experienced modification, charged to these challenged TD payments.

- **EMPLOYER CHALLENGES SETTLEMENT:** The above example is extreme and rare, since this does not often occur. However, if the Employer does have valuable information, even if it would not otherwise tend to defeat the claim or a portion thereof, this should be shared with the carrier with follow up. Establishing a collaborative and timely dialogue is likely to have a much more successful claims outcome, then waiting until after the settlement occurs or on the eve of settlement. Providing the notice to the carrier that there are facts which would tend to disprove the claim, should be supported by whatever facts, documents and evidence, which exists to support the basis for the notification.

- **COLLABORATIVE APPROACH:** Working with the insurance carrier early in the case is more productive in most cases then advising them late in the case that you are objecting to their intended settlement. A settlement should not be considered either a concession or a surrender, since the reality of workers' compensation is that most cases actually resolve by settlement rather than by a WCAB hearing on the merits and determination by a Workers' Compensation Administrative Law Judge. The fact is very few cases actually are tried to a conclusion with a "take nothing result" although these do occur. Therefore, the other "extreme" position that "we will lose anyway" should also be avoided. However, the provisions under the Labor Code permitting Employer objections to settlement really provide a very limited form of relief. And,

the relief is depended on a number of things taking place, the mechanics of which are not presented in the Labor Code, which include, having to request a WCAB hearing and then producing Employer-provided evidence upon which a "de novo" hearing would result in the Employer prevailing on the disputed issues, which surround the experienced modification for the charges relating to the contested benefits. This is a process rarely undertaken because of the time, delays, and uncertainty, not to mention the costs associated with this effort. Therefore, another approach is to arrange for a meeting with the carrier, presumably with the Broker present, and then simply present the "information and evidence" upon which the position is being taken that settlement should not occur. Even if the carrier continues on the path to settlement, they may be able to actually produce a lower settlement product, by having this additional information with which to negotiate a better settlement.

MEDICAL PROVIDER NETWORKS: (MPN); ESTABLISHING CONTROL OVER MEDICAL TREATMENT DURING THE 90 DAY PERIOD WITHIN WHICH TO INVESTIGATE AND DECIDE UPON COMPENSABILITY

- In a "nutshell," there is a 90 day period within which to deny a claim, once an Employee's Claim Form (DWC-1) is "served" upon the employer. In order to encourage prompt investigations and to discourage delays, a further provision mandates that during the "investigative" period prior to the time when the carrier decides to accept or reject the claim, they must offer medical treatment to the employee, *up to the time when they decide to admit or deny the claim or reach the cap of $10,000, which ever first occurs.* (Labor Code 5412(c).

- During the so-called "90 day period," the carrier must offer all necessary *medical treatment. But, that treatment is provided through the Medical Provider Network, so that the carrier has some control during this time.* This can be an enormous advantage, especially in claims which are ultimately accepted, which means that the medical treatment was under the control of the MPN, during both the delay and post-delay acceptance period. This control is LOST if the carrier refuses to provide the medical treatment, fails to establish and provide proper postings and notices for the MPN or issues a rejection of the claim. A rejection occurs when the carrier decides that they are not accepting compensability. Here, the injured worker is now able to obtain medical treatment on a self-procured basis and *with physicians and providers who are likely to be out of the MPN.*

- With seemingly increased frequency, we are e receiving a substantial number of questions from our clients as to what strategy to pursue, during the so-called "delay period," during which time the Employer is investigating the claim but is also required, under Lab C 5402(c), to provide Labor Code 4600 medical treatment up to the statutory cap of $10,000 or until the claim is either accepted or rejected. The current case law is anything but well-settled and while this may sound a bit vague, each case must be viewed and analyzed on its own, so that it is unlikely that a single, central strategy should be used in all claims.

- The ultimate question is, "Should I deny the claim as soon as I have sufficient facts and a legally justifiable reason for doing so," or should we run the time further, so we can conduct further investigation, while providing 5402(c) medical treatment? Alternatively, should we simply deny the claim early, and start the PQME 4060 discovery process?

- The ultimate decision of which course of action to take reflects a balance between the risks of authorizing care for claims or specific body parts under delay vs. the strategic benefits of controlling medical treatment within your MPN, while providing ample opportunity to perfect your full investigation and discovery. An early denial, can keep you on the discovery defensive, so you have to look at the opponent and weigh the risks and benefits accordingly. And of course, with a long-term Employee, it may simply make good sense to consider admitting the injury (or part of) and then controlling medical care within the MPN. This becomes even more compelling when you have a reasonable belief that with the type of job functions performed, combined with prolonged exposure and pathology, that ultimately you will be hit with injury anyway.

THE POST TERMINATION DEFENSES

- **POST-TERMINATION DEFENSES**: A workers' compensation claim is being made, presented or maintained at a time *after the Employee has received notice of an involuntary termination, whether in the form of a notice of layoff or termination.* Often seen as retaliatory, the Employer may believe that the claim is defendable because it is first presented after the notice of layoff or termination is afforded. Unfortunately, the post-termination defenses look better in writing then they work in actual practice. The truth is they are really "porous" and therefore contain enough "exceptions" in order to effectively render them useless, in most cases.

- **THE DEFENSE IS TRIGGERED BY A NOTICE OF AN INVOLUNTARY TERMINATION OR LAY0FF**: Often misunderstood is the fact that there has to be a "notice" (oral or written) of an involuntary separation from the employment. *If the employee quits without notice to the Employer and the Employee had no prior "notice" that he or she was being laid off or otherwise terminated from the employment, then the post termination defenses are inapplicable. So, voluntary "quits" do not count here. The WCAB and the Courts will look at the facts in order to determine whether the termination was really involuntary. The facts will therefore decide whether the post-termination defenses apply.*

- **POST TERMINATION DEFENSE** – PHYSICAL INJURIES: [Labor Code 3600(a) (10]: The Labor Code has three exceptions to the rule: (1) The employer has notice or knowledge of the injury before the notice of layoff or involuntary termination occurs: (2) there are medical records existing prior to the notice of layoff/termination which contain evidence of the injury. (3) The actual "date of injury" takes place after the notice of layoff. EXAMPLE: Notice of plant closure takes place on Friday, 9/1/12 and the injury takes place of Monday, 9/3/12. Here, there is no post-termination defense because the injury took place after the notice of layoff/termination. The same thing is applicable to cumulative trauma claims, where often the "date of injury" is a legal dispute, with the Employee contending that the so-called "date of injury" occurred after the layoff/termination notice.

- **POST TERMINATION DEFENSE: MENTAL/PSYCHE:** [Labor Code 3208.3(e)]. These are the same defenses as above, except here, the existing medical records must contain evidence of *treatment for the claimed psyche injury.*

- **BOLSTERING THE DEFENSE**: The Employer helps the carrier by providing the documentation relating to the critical "timing issues." (1) In what form did the Employee receive his/her notice of layoff/termination? Was this written? If so, did the Employee sign the document? If not, was it witnessed by other Employees? (2) Was the notice confirmed by subsequent E mail, memorandum or some other form of documentation? (3) Did the Employee ever act in acknowledgement of this notice? (4) When did the Employer receive first notice or knowledge of the industrial injury? (5) In what form or content? (6) Did the Employee report the injury before the actual date last worked? (7) Did the Employee quit? (8) If so, when; (9) Was this simple job abandonment or did the Employee say something or communicate the intention before the act of quitting?

PSYCHIATRIC CLAIMS: "GOOD FAITH PERSONNEL ACTIONS"

- A psychiatric claim may be defendable if it can be shown by the Employer that at least 35% of the "actual events" at work were the result of lawful, non-discriminatory good faith personnel actions.

- The "good faith personnel actions" must pass a multi-part test. This test was established in the WCAB En Banc decision in the case of **Rolda v Pitney Bowes**[ix] and is often referred to as the "Rolda" test or checklist.

- This includes the following: (1) whether actual events of employment are involved. This is a factual/legal issue for the WCJ to determine, not a medical issue. (2) The good faith personnel actions must be deemed a "substantial cause" of the psychiatric injury, meaning at least 35-40%, from all other causes: (3) whether any of the actual events of employment were personnel actions, and if so, whether any of them were lawful, nondiscriminatory, good faith personnel actions. These are factual/legal issues for the WCJ to determine. (4) Finally, if any lawful, nondiscriminatory, good faith personnel actions contributed to the injury, medical evidence is required to determine whether such personnel actions were a substantial cause, 35 to 40 percent, of the injury, as defined by subdivision (b) (3).

MANAGING CLAIMS FROM THE EMPLOYER PERSPECTIVE

- **THE ROAD TO WORKERS' COMPENSATION CLAIMS SUCCESS IS PAVED WITH CLOSED FILES:** It is my experience that for admitted injuries, 70% or more of the incurred and current reserves relate to medical treatment and medical-legal expenses. The main driver for claim costs is nearly always medical care and very rarely indemnity. Getting claims closed should be a long-term goal, driven by an ongoing strategy. You should operative within a culture of closing claims. Your interface with the carrier should therefore take place within the continuing focus of "how do we close this claim as soon as possible?

- **LITIGATED CASES AND MEDICAL TREATMENT:** For admitted injuries where the injured worker has an attorney, it is almost a "duty" for the attorney to gain control over medical care. That is their operating blueprint for the claim. This can be done either with selecting a friendly and applicant tending physician within the MPN or by simply adding body parts to the admitted claim mixture and then going out and picking a very friendly, non MPN physician. Either way, the attorney is attempting to wrest and then maintain control over medical care. That "control" means that the Employee-friendly physician will be determining the course of treatment, the methods and extent thereof, the modalities involved, the duration and course and whatever necessary diagnostics are required, together with medicines and durable medical equipment. Also, that doctor will set forth the treatment plans in ongoing PR-2's, every 45 days, so that ongoing care is shaped in the direction most conducive to the interests of the injured Employee.

Your carrier is then left in the position of using their utilization review process to determine the necessity of specific requests for medical treatment and the QME process for the ultimate resolution of any pending medical disputes.

- **EMPLOYER CAN HELP BY GETTING THE EMPLOYEE BACK TO WORK:** Anecdotally, the best "medicine" is returning the injured worker to work, whether regular work, with temporary modifications or restrictions, or with permanent restrictions resulting in modified work or alternative work. This seems to take a lot of the "incentive" for the Employee to want to continue with prolonged and unnecessary medical treatment and this can also change the focus of the injured worker into a more positive vector.

- **DON'T "CRY WOLF"**: You should understand that a claim is not necessarily suspicious simply because it was reported after the shift or that no one saw it "happen." Instinctively, most people don't like going to doctors and therefore if you have an Employee who went that day to the emergency room or to the Employer-directed industrial clinic, then you are likely dealing with an admitted injury situation. Of course, the ensuing investigation can change the facts, so you should have a process in place for prompt reporting to your carrier. Don't wait. Also, if you form a pattern and practice of placing every injury within a context of suspicion, you may be "crying wolf," so be careful and methodical. Trust the process and let the process work for you.

- **SHARING INFORMATION WITH THE CARRIER:** Establish a process where someone from your company will be responsible for providing your carrier with whatever they need. Know which examiner has been assigned to your claims and then maintain communications. Give them the wage and time records, when they ask. The faster you respond the more information they have at hand with which to make timely decisions. Give them information on the "red flags" and don't wait until a year later, when it may be too late. During the investigation phase, make sure that the staff is aware of the importance of cooperating with the carrier, so if they want to meet with potential witnesses and take their statements, this should be strongly encouraged.

- **STAY CONNECTED WITH YOUR CLAIMS:** Whether they are with your present or former carrier, remember that the Experience Modification is determined over a three year period, so stay in contact with these claims. Reserves and incurred amounts should be reviewed periodically. A list of claims both with your present and former carrier should be obtained and the case status should be visited periodically. Often, parties will use Agreed Medical Examiners on claims which are admitted. Ironically, this probably ends up costing much more and can usually prolong the claim. At the same time, don't wait 2 years to ask for information on a claim. Be proactive! You and your Broker should get a list of the open claims and follow their course. Encouraging early resolution is often the leading move towards best claims outcomes.

- **FOLLOW THE MONEY**: The claims which have the most impact should be followed more closely. You can ask your Broker to obtain claims information updates and reserving information, in order to check on the reserves. This can also be undertaken in conjunction with a claim review and a formal demand for information under Labor Code 3761. (above)

- **CLAIM REVIEW WITH CARRIER**: Remember, you are entitled not only to certain information relating to the claims as they affect premium but also an "explanation" from your carrier on the establishment of the case reserves, the basis for the reserves, the amount spent for medical treatment, medical-legal and other costs associated with the handling of the claim. This "explanation" is framed around the word "discussion" in the Labor Code. Does this mean a dialogue or a formal meeting? Common sense and plain meaning would dictate "yes," though some carriers might decide to provide you with a written narrative answering and responding to your written or E mail based questions or concerns. The important thing is that they address and respond to your inquiry with more than some numbers. They need to provide the reasoning (rationale) behind the reserving decisions. This is the "heart" of the process. In this regard, you need to know not only the reserve history but also the history of payments made.

- **DO YOUR PART**: (1) Make sure you have the correct and updated Employee notice posters for workers' compensation benefits (Labor Code 3550) and the medical provider network in a "conspicuous" location frequented by employees and printed both in English and in Spanish, if you have Spanish speaking employees.[x] (2) MPN notices both pre and post injury needs to be accessible: (2) establish a system to encourage prompt employee reporting of injuries. Work with your carrier to maintain and conduct your safety program. Be proactive about employee reporting of injuries and about safety. (3) Document absences from work; (4) Maintain documentation for employee performance, including incidents, counseling, warnings either informal or formal, and other employer actions. (Good faith personnel actions). (5) Report claims immediately; (6) Document reported injuries; (7) Watch for "red flags" and report these to your carrier promptly. (6) Do you have a return to work program? (7) make sure HR is connected to Employment Law Counsel on issues of return to work, reasonable accommodation and the interactive process under FEHA. Get advice!

WHAT ABOUT LARGE DEDUCTABLE PROGRAMS OR FIXED COST POLICIES WITH SUBSTANTIAL PREMIUM?

- Under some programs, the Employer has a much higher level of involvement, as often there is a high deductible and therefore it is "your money" before a certain level. Here, you may have a greater need to be active not only in the monitoring of loss runs and reserves but in getting involved in actively monitoring the actual claims handling activities. A "team approach" would define the respective roles and responsibilities of the Claims Administrator and the insured Employer, so that the claim functions are carried out by licensed claims professionals. Also, the program should be designed with the intent to preserve whenever possible, confidential communications with counsel and therefore the attorney-client privilege and work product.

- **EMPLOYER INVOLVEMENT IN CLAIM**: In many cases, Employers want to be engaged and actively involved in the claim, from its very inception. This means the Employer is expected to have dialogue and discussion with the claims administrator over the compensability issues and what activities and actions are needed, in order to complete the compensability investigation to facilitate timely claims decision making.

- **TEAM APPROACH**: A "team approach" can also include a shared philosophy on whether to use Agreed Medical Examiners or PQME's to resolve disputed medical issues, when to engage defense counsel, time frames and expectations, settlement philosophies, claim exposure analysis and settlement valuation, settlement timing and the initiation and completion of discovery. Will the Employer attend depositions? What items and correspondence are to be copied to the Employer, within the limitations of Labor Code 3762?

- **THE DOUBLE PLAY STYLE PROGRAM:** The adage that bad cases only get worse is illustrated by the observation that often, claims and legal folks are simply stymied on how best to advance the vexing claim to ultimate closure. It also seems that in many instances, "bad claims" start out with simple injuries, which over the passage of time, can frequently migrate into lengthy and chronic medical "nightmares" which effectively transform a simple case into complex and high level exposures. The concept of Double Play is borne from the thought that help should be given in a collaborative, non-confrontational manner and within an environment which harnesses the best energy and skills from multiple discipline participants. The environment should also nurture learning and promote education and knowledge transfer. Double Play is simply a program in which a group of passionate claims and legal professionals meet in order to review difficult or problem claims, with the intention of fostering "action plans" and "ideas" which come from integrated thinking and collaborative dialogue. The guiding underlying philosophy is the promotion of inherent value in providing collaboratively based claim specific help, within a non-confrontational and supportive climate, in order to offer effective assistance on cases, which require a greater level of management oversight.

DOUBLE PLAY EXPLAINED IN A NET SHELL:

- **THE DOUBLE PLAY GROUP:** The Double Play group can consist of the Claims Examiner, Supervisor and/or Claims Manager, as well as the defense attorney. When appropriate, others should attend, including a Case Manager Nurse, MSA Expert, Structured Specialist and Investigator.

- **PRESENTATION FORMAT**: Agreed upon format for presentation. It is recommended that a short form or claim summary be provided to the group, at the time of presentation. This should contain essential claim information but should not form a "barrier" by containing too much detail, so that the form effectively serves to discourage the seeking of help. The form should be "user friendly" and therefore easy to read and follow. It is also recommended that the form set forth the type of help or assistance being sought by the group.

- **PRESENTATION**: Presentation by Claims Examiner. Facts and issues are presented along with the essential call for help and assistance. It is suggested that the presentation generally follow the form, so that the group can follow along easily.

- **GROUP DISCUSSION**: Following the presentation, the group discussion begins. This should be a healthy "give and take," where questions are asked and thoughts are given freely and without fear of criticism. The discussion centers on the important issues, featuring "out of the box thinking" and "creative" solutions to move the matter forward and towards closure. It is generally thought that a single session should not extend more than 3 hours, nor should cover more than 8-10 cases. Also, the discussion should take place within the context of how to export and therefore leverage the Double Play "knowledge nuggets" across the organization.

- **AGREED UPON ACTION PLAN**: Agreed upon Double Play Action Items: This should be confirmed and placed into the claim notes or other claims management system. The plan should include the strategy and the action items to support that strategy, including who is responsible and the time frames applicable. A Double Play staffing summary is recommended on a file-by-file basis, in order to achieve and maintain claims handling continuity.

- **FOLLOW-UP:** The second element of Double Play is the follow up on the action items and if appropriate, a second Double Play visit by the group.

- **RETROSPECTIVE REVIEW**: The program should be reviewed periodically and data should be maintained in order to determine whether the D/P format is having success.

[i] Labor Code 5401(a) defines "first aid" as any one time treatment and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters or other minor industrial injury, which do not ordinarily require medical care.
[ii] Labor Code 5401(a)
[iii] Labor Code 5402(a)
[iv] Labor Code 5402(b)
[v] Labor Code 3202.5, 5409.1(a), 8 CCR 14001
[vi] Labor Code 3761(b), 5409.1(a), 8 CCR 14001
[vii] Labor Code 3761(b)
[viii] Labor Code 5813(a) and 8 CCR 10561 (The failure to provide service or proof thereof could be deemed a bad faith
[viii] Labor Code 5813 and 8 CCR 10561 (The failure to provide service or proof thereof could be deemed a bad faith tactic and could subject carrier to attorney's fees and other costs in addition to another sanction up to $2,500 payable to the General Fund.
[ix] Rolda v. Pitney Bowes, Inc. (2001) 66 CCC 241
[x] This is a very important statute. The Employer is required to keep the poster in a conspicuous location frequented by employees and where the notice may be easily read by employees during the hours of the workday. The notice requirements also mandate notice under 8 CCR 9783, for medical treatment, including the right to change treating physician and the right to pre-designate personal physician.