

LET THE CLAIMS BEGIN... THE FIRST 90 DAYS*

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The first ninety days of a claim are critical for establishing the course of the entire case. It is during these first ninety days that the claims professional should be investigating the claim, advising the employee of his or her rights under workers' compensation law, and providing medical treatment as appropriate. However, in order for the claims examiner to carry out these responsibilities, the employee needs to cooperate with the investigation and meet his or her obligations as well.

In this article, we will present a general overview of the basic rights and responsibilities of the parties during the first ninety days.

I. The Injury

An "injury" is defined by Labor Code §3208 as including "any injury or disease arising out of employment, including injury to artificial members, dentures, hearing aids, eyeglasses and medical braces of all types." However, "eyeglasses and hearing aids will not be replaced, repaired, or otherwise compensated for unless injury to them is incident to injury causing disability."

For example: An employee is struck by another vehicle while she is driving the company truck for work purposes, and her head hits the steering wheel. Her glasses are crushed, and she also sustains a head injury as a result of the impact. The glasses may be replaced, repaired, or otherwise compensated for. However, if she is unharmed by the collision, but the glasses are damaged, the employee is not entitled to compensation for the damage to his or her glasses under the Labor Code.

II. The Claim Form

When to Provide the Form

The claim form shall be provided to an employee within one working day of receiving notice or knowledge of an injury, which results in lost time beyond the work shift at the time of injury, or medical treatment beyond first aid. (Labor Code §5401(a)) The terms “notice,” “knowledge,” “working day,” and “first aid,” all have specific meanings as set forth below.

Interestingly, a “working day” is not actually defined in the Labor Code. However, it most likely means a day when the employer is conducting business. The extremely conservative approach is to consider every day a “working day.”

The employer receives “notice” or “knowledge” of an injury several ways. Under Labor Code §5400, the employee is required to serve the employer with written notice, signed by the employee or someone on his or her behalf, or in case of death, by a dependent or someone on that person’s behalf. The service of written notice is supposed to occur within 30 days of the injury.

However, under Labor Code §5403, neither the employee’s failure to give notice under Labor Code §5400, nor any defect or inaccuracy in the notice that is provided by the employee will bar his or her recovery, provided that the employer was not misled or prejudiced by such failure.

Additionally, “[k]nowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendant, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.” Thus, there are few situations where the employee would be barred from recovery based on lack of notice or knowledge by the employer.

For workers’ compensation purposes, “first aid” is defined 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;” however, “minor industrial injury,” but does not include serious exposure to a hazardous substance as defined in §6302(i). (Labor Code §5401(a).) There is also another definition of “first aid” for purposes of Cal/OSHA, under 8 Cal.Code.Reg.

§14300.7(b)(5), which is more specific than the definition for workers' compensation under the Labor Code.

What if the Claim Form was not Provided?

If the claims administrator obtains knowledge that the employer has not provided a claim form, it shall provide one to the employee within three working days of its knowledge that the form was not provided. (8 Cal.Code.Reg. §10140)

If the claims administrator *cannot determine* if the employer has provided a claim form to the employee, the claims administrator shall provide one to the employee within 30 days of the administrator's date of knowledge of the claim. (8 Cal.Code.Reg. §10140.)

The Notice of Potential Eligibility for Workers' Compensation Benefits

A notice of potential eligibility for benefits under the workers' compensation law needs to be provided at the same time the employer provides the claim form, and "insofar as practicable, the notice of potential eligibility for benefits required by this section and the claim form shall be a single document and shall instruct the injured employee to fully read the notice of potential eligibility." (Labor Code §5401(b).)

The claim form and notice of potential eligibility for workers' compensation benefits must be provided to the injured employee personally or by first class mail. (Labor Code §5401(a).)

Frequently, the notice of potential eligibility is referred to as a "*Reynolds* Notice," after the 1974 Supreme Court en banc decision that held that the employer's failure to inform the employee of his rights when he was unaware of them, and notify the employee that it was denying liability for benefits, estopped the employer from asserting a statute of limitation defense. While the specific regulations relied upon in the *Reynolds* case were repealed, there are current existing regulations which would likely support the Court's reasoning.

After the Claim Form is Provided

Under 8 Cal.Code.Reg. §10140, within one working day or receipt of a claim form, the employer shall date the claim form and provide a dated copy of the completed form to the employee and the employer's claims administrator. (*See also* Labor Code §5401(c).)

The employee is to file the completed claim form with the employer, either by personal delivery or by first-class or certified mail. (Labor Code §5401(c)) If the claim form is *not* filed, the employer still has a duty to investigate the claim. (*see* 8 Cal.Code.Reg. §10109.) However, the employer does not need to provide medical treatment pursuant to Labor Code §5402(c) until the claim form is filed. Furthermore, under Labor Code §5401(d), the employee is not entitled to late payment supplements under Section 4650(d) until the claim form is filed with the employer or prior to the injured employee's request for a medical evaluation under §§4060, 4061, or 4062.

Within one working day of the claim form being filed, the employer is to authorize medical treatment pursuant to the medical treatment utilization schedule adopted pursuant to Labor Code §5307.27 (which incorporates ACOEM guidelines), and continue to provide treatment until liability for the claim until it is accepted or rejected. Liability for medical treatment until that time is limited to \$10,000.00. (Labor Code §5402(c).) This treatment does not give rise to a presumption of liability on the part of the employer. (Labor Code §5402(d).) Under Labor Code §4600(a), that is treatment that is "reasonable and necessary to cure or relieve the injured worker from the effects of his or her injury."

III. Investigating the Claim

The claims administrator has a duty to conduct a reasonable, timely, and good-faith investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit. (8 Cal.Code.Reg. §10109) The investigation should encompass the medical, legal, and factual bases to accept or deny the claim.

Medical Basis

The claims administrator should review the available medical records and reports to determine compensability, and the employee may be asked to provide a statement disclosing all previous permanent disabilities or physical impairments, pursuant to Labor

Code §4663(d). The employee may also be asked to sign a HIPAA release to access medical records.

Pursuant to 8 Cal.Code.Reg. §30(d)(1), after a claim form has been filed, the claims administrator, or if none the employer, may request a panel of Qualified Medical Evaluators only as provided in Labor Code §4060, to determine whether to accept or reject a claim within the ninety day period outlined in Labor Code §5402(b), and only after providing evidence of compliance with Labor Code §§4062.1 or 4062.2.

Legal Basis

Labor Code §3600 sets forth the conditions of compensation for employer liability. Part of the investigative process includes determining whether the facts would give rise to a situation where the employer should argue, for example, the injury arose out of a voluntary, off-duty recreational activity, or was caused by intoxication. Perhaps this injured worker is not an “employee,” but rather an independent contractor. The claims administrator may wish to consult with defense counsel regarding these issues.

Factual Basis

Of course, the claims administrator will likely seek to interview the employee to obtain a history of the injury (what happened, were there any witnesses, etc.). He or she may also interview supervisors, co-workers, and other witnesses in determining the facts of a claim. The claims administrator should be aware that any recorded or written statements are not protected by any legal privilege and may be discoverable in litigation.

Pre-Application Investigation

The filing of the Application for Adjudication of Claim (“Application”) is critical for purposes of conducting discovery. Until the Application is filed, the Workers’ Compensation Appeals Board (“WCAB”) has no jurisdiction over any aspect of a workers’ compensation claim. (*See Yee-Sanchez v. Permanente Group* (2003) 68 CCC 637.) If an Application has not been filed, the WCAB cannot conduct hearings or issue orders for compelled discovery, nor may the employee’s deposition be noticed or records subpoenaed.

However, there are pre-Application discovery efforts that do not involve the judicial process (including surveillance) that are generally permissible and often necessary to determine whether liability should be accepted or denied after a claim form

is filed. Again, the claims administrator may request that the injured employee sign medical releases and voluntarily provide documents. He or she may also interview the employee and witnesses.

While the employer may want to consider filing an Application in order to permit other forms of discovery, if the employer files an Application for Adjudication and the employee is unrepresented at the time, the employer will be liable for any attorneys' fees incurred by the employee in conjunction with the Application, subject to Labor Code §4906.

Failure to follow the pre-Application rules for investigation may result in monetary sanctions under Labor Code §5813, as well as evidentiary sanctions (exclusion of improperly discovered material).

IV. Delaying a Claim

If the claims administrator decides to delay a decision regarding acceptance or denial of a claim, it is essential that a delay notice advising the injured employee of how to obtain medical treatment in accordance with ACOEM guidelines be provided. (Cal. Code Regs. §9812.)

While the claim is delayed or investigated, all medical care which is ACOEM or guideline compliant must be provided to the injured employee and paid from the workers' compensation claim. Payments for medical treatment will continue to be made up to a maximum of \$10,000.00 in accordance with ACOEM guidelines or until the claim is denied. While payment for medical treatment must be made during this time, there is no legal right created for recovery of those amounts from the injured employee, medical provider, or the major medical plan if or when the claim is denied.

The claims administrator does not have to pay temporary disability benefits. However, the Notice of Delay must be sent to the injured employee. Even if the claims administrator delays a claim, it is important to remember that an investigation should always be conducted.

What Can the Injured Employee do?

If an employee's claim is delayed, the employee may seek an Expedited Priority Hearing. Pursuant to Labor Code §5502, an injured employee may seek an Expedited Priority Hearing and decision upon filing of an Application and Request for Expedited Hearing showing a bona fide dispute to the entitlement to medical treatment.

The issues are limited to whether a claim form has been filed; whether the claim has been accepted or rejected; a general finding of whether medical treatment must be

provided under Labor Code §5402(c); and the liability for medical treatment and the interval of such liability. If this occurs, the parties may request a continuance for a priority or status conference to address the issue of AOE/COE.

Who Selects the Medical Services Provider?

As of January 1, 2005, whether the employee or employer is entitled to select the medical service provider depends on whether the employer has a Medical Provider Network (“MPN”). If the employer does not have a MPN, within the first 30 days of a claim, the employer controls medical treatment. After the first 30 days, the injured employee retains control over treatment. However, the claims administrator must still direct the employee where and how to obtain medical treatment. If the employer has a MPN, the claims administrator must determine if the employee has pre-designated a physician, the injured employee is entitled to treat with the pre-designated doctor (except for chiropractors).

When the employee notifies the employer or insured employer of the injury or files a claim for workers’ compensation, the employer or insurer shall arrange an initial medical consultation with a physician within the MPN. (*See* 8 CCR §9767.6.) The claims administrator or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the initial visit that is scheduled with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

The employer or claims administrator must send the employee notice regarding the employee’s rights under the MPN and the procedures to go about accessing the MPN along with the claim form and notice of potential eligibility for benefits under the workers’ compensation system. Under *Knight v. UPS*, the employer can be liable for medical treatment that was self-procured because of the employer’s neglect or refusal to provide reasonable medical treatment by not providing the employee with notice of his or her rights under the MPN. (*See* 8 Cal. Code Regs. §9767.12.)

Transfer Into the Medical Provider Network

If the employer or claims administrator implements an approved MPN, and decides to transfer the covered employee into the MPN, it should confirm the employee’s condition does not meet one of the four exceptions prohibiting transfer into the MPN as outlined in 8 Cal. Code Regs. §9767.9.

If the employer or claims administrator decides the employee’s condition does not fall under one of those exceptions, it should notify the employee of the decision to transfer medical treatment into the MPN and also send the notification to the primary

treating physician. If the employee seeks to dispute the decision to transfer him or her into the MPN, the process for doing so is set forth in 8 Cal.Code Regs. §9767.9.

V. Denying a Claim

Although “failure to cooperate” in and of itself is not a proper basis to deny a claim, 8 Cal. Code. Regs. §10108(e) states: “Penalties will not be assessed [against the employer/insurer] for an act or omission where an injured workers’ unreasonable refusal to cooperate in the investigation has prevented he claims administrator from determining its legal obligation to perform the act.”

What happens if the claim is not denied within 90 days?

If liability for claim is not rejected within 90 days after the date the claim form is filed, Labor Code §5401 provides that the injury shall be **presumed compensable**. The presumption is rebuttable **only** by evidence discovered subsequent to the 90-day period which could not have been discovered prior to the 90-day period. (Labor Code §5402(b))

Qualified Medical Evaluation Regulations

There are new Qualified Medical Evaluation Regulations, as of 2009, pertaining to denial of claims. Under 8 Cal. Code Regs. §30(d)(3), whenever an injury or illness claim of an employee has been denied entirely by the claims administrator, or if none by the employer, **only the employee** may request a panel of Qualified Medical Evaluators, as provided in Labor Code §§ 4060(d) and 4062.1 if unrepresented, or as provided in Labor Code §§4060(c) and 4062.2 if represented.

Under 8 CCR §30d)(4), after the ninety (90) day period specified in Labor Code §5402(b) for denying liability has expired, a request from the claims administrator, or if none from the employer, for a QME panel to determine compensability shall only be issued upon presentation of a finding and decision issued by a Workers’ Compensation Administrative Law Judge that the presumption in Labor Code §5402(b) has been rebutted and an order that a QME panel should be issued to determine compensability. The order shall also specify the residential or, if applicable, the employment-based zip code from which to select evaluators and either the medical specialty of the panel or which party may select the medical specialty.

The New Panel QME Regulations (adopted February 17, 2009) can found at: http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm

VI. Post Application Discovery

While there are limitations on what discovery can be conducted prior to the filing of an Application for Adjudication of Claim, once an Application is filed there are no limitations. After the filing of the Application, either party may invoke the judicial process to conduct compelled discovery (i.e., noticing a deposition, subpoenaing a witness to a deposition, or subpoenaing medical records and other documents. (See *Yee-Sanchez, supra.*)

VII. Conclusion

For the reasons outlined above, the first ninety days of a claim are critical. While this article has outlined the basic rights and responsibilities of the parties during this period, each claim is unique, and there may be specific issues that arise where legal counsel may assist in the decision-making process.

**This article is intended to provide a general overview, but is not intended to provide legal counsel or advice, and should not be construed as such. Each case is unique and is controlled by specific facts. Please consult a qualified legal professional regarding your specific legal questions.*