CALIFORNIA
WORKERS' COMPENSATION

THE PROACTIVE EMPLOYER

- ***The Ever Expanding Role Of The Employer***
- ***Prevention Strategy***
- ***Changes in the System (SB 899)***
- ***Return to Work Issues***

May 17, 2010

PRESENTED BY:

Peter E. Louie, Esq. *[plouie@louielaw.com]*
Nishi C. Reddy, Esq. *[nreddy@louielaw.com]*

303 N. GLENOAKS BLVD., SUITE 400
BURBANK, CA 91502-1116
(818) 461-9559 * (818) 461-9545 FAX

500 N. STATE COLLEGE BL, SUITE 1100
ORANGE, CA 92868
(714) 919-4261 * (714) 919-4262 FAX

3323 WATT AVE., SUITE 264
SACRAMENTO, CA 95821-3809
(916) 797-4580 * (916) 797-3056 FAX

225 BUSH ST., SUITE 1600
SAN FRANCISCO, CA 94104-4215
(415) 439-8365 * (415) 439-8371 FAX

Website: www.louielaw.com

EMPLOYER'S ROLE BEFORE 1990

Prior to 1990, the employer's role in Workers' Compensation was fairly minimal. An injury would occur at work and the employer would report the injury to the carrier. The carrier would then adjust the claim and the employer would have very little involvement in the claims handling.

CHANGES IN THE EARLY 1990'S

Due to some changes in California in the early 1990's, Workers' Compensation became much more difficult to adjust. As a result, the employer's role began to expand.

1. Economy - In the early 1990's, the economy in California was not doing very well. There were many layoffs, plant closures and companies leaving the State of California.

   As a result, there were many unemployed workers. To survive, they could either find a job, but jobs were scarce, or collect unemployment or try to collect disability or Workers' Compensation.

   Given the choice between unemployment and disability, disability paid more and, therefore, was an attractive option. The only problem was that to collect disability or Workers' Compensation you had to be injured on the job.

   In order to obtain disability benefits then, some injured workers decided to file Workers' Compensation claims under fraudulent pretences. Workers' Compensation fraud became ramped in the early '90's, and many claims were filed simply because injured workers had no alternative, other than unemployment. People would recruit injured workers at the Unemployment Offices to file Workers' Compensation claims. Primarily doctor groups would start the fraud procedure by recruiting unemployed workers, asking them if they had any physical complaints, and then filing Workers' Compensation claims on their behalf. That doctor would then certify the applicant for disability and the applicant would receive disability for up to a year's time, while receiving what most likely would have been unnecessary medical treatment.

   As this fraud continued to escalate in the early '90's, obviously costs and litigation started to increase. Workers' Compensation became a very prominent subject in the economy, and that necessitated the increased role of not only the adjuster, but the employer as well. It was at this point and time that the employer's role became much more involved, to the point where now the employer's role is vital at every step of a Workers' Compensation claim.

2. Increase in Litigation - As is usual in the State of California, whenever there is a new form of litigation, California takes that new form of litigation and runs with it. In the early '90's disability discrimination became quite prevalent. Even before the *Americans With Disability Act*, disability discrimination was prevalent in California, and now has become prominent in light of the fact that ADA Claims are now being filed regularly as well.

   Essentially, prior to 1990, when an injured worker stepped into the Workers' Compensation world, the employer was left out of the handling of the claim. Now, if the employer discriminates against the injured worker in any way, shape or form, the injured worker can then allege disability discrimination. As a result, the employer's role became more important. Every injured worker, whether there was an issue involving employment, had to have the employer's input and decision as to whether to return the injured worker to work on a modified basis, temporary basis or permanent basis. All these decisions could be scrutinized to the point where an allegation of disability discrimination can be made. Therefore, the employer's role now expands even further with a threat of civil litigation.

3. Changes in the Law - Several laws came into effect in the early 1990's that required the employer's active involvement in the litigation of claims, to include the 90-day rule and the treating doctor control rules. As a result of these early laws, the employer's role again was expanded, and even now, after SB 899 completely reformed the Workers' Compensation System, the employer's role is still vital in the handling of a Workers' Compensation claim.

THE 90-DAY RULE

Labor Code Section 5402 came into effect for injures after 1/1/90. This law drastically changed the role of a Workers' Compensation carrier, as well as the employer as a result. Labor Code Section 5402 states as follows:

> *"(a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, 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.*
>
> *(b) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period."*

This Labor Code has a long ranging affect on the handling of Workers' Compensation claims. This law was primarily designed to force insurance carriers to handle claims on a timely basis. Essentially, if there is a disputed claim, carriers in the past used to be allowed as much time as they wanted to investigate and then make a decision. In the meantime, the injured worker would have to wait without any benefits for that decision to be made. Noting the hardship this would cause a legitimate injured worker, this law was placed into effect to force carriers to make a decision within 90 days. How this law affected carriers was quite drastic in the early 1990's. All of a sudden, with the increase claims due to the economy and the prevalence of fraud, Claim Adjusters were inundated with claims, and many times would fail to timely deny a claim. As a result, a claim that should have been denied and not paid at all was now being paid, due to this law, making the injury now presumed compensable. The penalty for not timely denying a claim was so severe, that all of a sudden this Labor Code became the subject of much scrutiny.

How the role of the employer became very involved was the fact that the 90-day rule does not start until the employer is made aware of a claim of injury. As you can see from the Labor Code, once the employer, by its management team, is aware of a work-related injury, they are required at that point to report the injury to the carrier, and that starts the clock. As a result, the employer's role in the 90-day rule starts from the very beginning. If an employer knows of an injury and fails to report it timely, the 90-day clock is still running, given that day one is the date that the employer became aware of the injury. Once you are aware of an injury, your must give the applicant a Claim Form to fill out and return, so that you can then turn it into the adjusting agency to start the process.

Labor Code Section 5401(a) indicates that within one working day of receiving notice or knowledge of an injury, which results in lost time beyond the injured worker's work shift at the time of injury or which results in medical treatment beyond first aid, the employer shall provide a claim form.

This Labor Code later clarifies that first aid means first aid" means 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.

Any injury otherwise would require the employer, upon being placed on notice of the injury, to give the applicant a claim form within one day. Again, the employer's role has become very clear. They start the clock and must, as a result, report injuries to the carriers timely, so that they can calculate the 90th day to avoid paying on a claim that should have been denied.

Again, the consequences of failure to timely deny a claim was quite drastic in the fact that you are now paying all benefits as if the claim were legitimate.

SUSPICIOUS CLAIMS

The 90-day rule only applies to claims that are suspicious in nature. Most injuries are admitted and the 90-day would not apply whatsoever. However, those rare circumstances where claims are being filed that are suspicious in nature, those are the claims that must be investigated

and timely denied if appropriate. It is these claims for which the 90-day period is most prevalent.

The next question, however, is how to identify a 90-day claim.

Some examples of suspicious claims include the following:

1. Post-Termination Claims - Any claim that is filed post-termination is suspicious in nature due to the fact that the claim was reported late, and there is always the ulterior motive of either retaliating against the employer or trying to obtain disability benefits.

2. Post-Layoff Claims - Any time a claim is filed post-layoff, when the end of a job is nearing, suggests an ulterior motive to the filing of the claim.

3. Any claim filed post personnel action - Specifically, if an injured worker has been written up or suspended or action was taken against and then files a claim thereafter, again there is the ulterior motive of retaliation.

4. Unwitnessed Injuries - Any injury that was unwitnessed has to be addressed with further investigation. It is too easy to report a claim of injury that was unwitnessed for you to simply accept the claim. Further investigation should take place.

5. Late reporting of claim - Any time a claim is reported late or post-incident, there is also a suspicion. Those claims should be investigated to inquire as to whether or not an intervening act actually caused the injury as opposed to the allegation of work injury. For example, if an injured worker comes in on a Monday, stating that he was injured on the Friday, previous, an inquiry should be made as to what the applicant did over the weekend, to try to determine whether an incident over the weekend actually caused injury as opposed to anything at work.

6. Psychiatric Claims - Any and all psychiatric claims should be investigated completely. Under the Labor Code, a psychiatric claim is only compensable when an employee can show that by "a preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury." Specially, an injured worker has to show that the work-related stress was predominant in his life causing the psychiatric disability. Predominant means 51% and, therefore, a full inquiry into the applicant's life has to be made to determine whether or not the allegation of work stress was at least 51%. As a result, an

inquiry into the entire life has to be made, to include an inquiry as to his/her non-industrial or home life. As a result, it is my recommendation that the deposition of an injured worker has to take place on all psychiatric claims to find out everything about the injured worker, outside of work. Only when a report shows that work stress is predominant is the claim compensable and, therefore, an investigation has to take place.

7. Continuous Traumas - Any time someone alleges an injury on a continuous trauma basis, as opposed to on a specific basis, has to be questioned. Under these circumstances, the injured worker is alleging that someone's repetitive job duties caused injury. Under those circumstances, it is primarily a medical issue as to whether or not the injury is industrial or not, and that injury should not be accepted without obtaining a medical opinion on the issue.

INVESTIGATION

Once you have identified a claim that is suspicious in nature that requires a 90-day investigation, the first thing that must be done is to report the injury timely to the carrier. The second thing that must be done is to identify to the carrier that from the employer's standpoint the claim is suspicious. For whatever reason you find the injury to be suspicious, that information must be passed on to the carrier, so that they are well aware not only of the filing of the claim, but that it is the employer's position that the claim should be fully investigated, rather than simply accepted and paid. Many times the insurance adjuster will receive a claim form that on its face appears to be within reason. For example, a claim form can simply state, "I was lifting 50 pounds and hurt my back." On its face, this does not appear to be a suspicious claim. However, if that claim was filed shortly after the injured worker was fired or written up, certainly that claim has to be found to be suspicious and should be investigated. That information can be provided by the employer only, and must be provided to the carrier, so that they can advise the injured worker that they are going to investigate the claim and will let the injured work know of their decision within 90 days.

The next step requires the employer's input as to providing whatever information they may have to assist and aid in the investigation of the claim. The injured worker's immediate supervisors and coworkers should always be made available for statements, to provide the employers input as to the circumstances of the allegation of injury.

Any rumors/gossip/innuendo that the employer knows of for this injured should be passed on to possibly be expanded upon by the insurance adjuster. For example, if an injured worker comes in on Monday and claims to have injured his back from an incident that happened the previous Friday, and there are rumors going around that the applicant may have moved over the weekend, that information should be provided to the carrier, so that they can further expand upon it. It could very well be that the applicant injured his back not at work, but rather from moving items at his home.

On a psychiatric claim, any rumors about the injured worker can be useful in determining potential sources of non-work-related stress. Specifically, if, for example, the employer is aware that the applicant is involved in a messy divorce, child custody issues, legal issues, etc., those issues could be vital to assisting in the defense of the claim.

The applicant's personnel file can be vital to the defense of the claim, as that personnel file may have much information as to the applicant's homes life and many other potential sources of stress. There could be garnishments, request for vacation time to attend court hearings, bankruptcies, medical issues, divorce proceedings, etc. Again, in these personnel files there could be a wealth of information that could be vital and useful in defending a psychiatric claim for Workers' Compensation benefits, as well as an orthopedic claim.

Any knowledge that you may have from your staff or from personal knowledge of prior injuries can be very useful in determining potential sources of apportionment, as well as disputing the injury in question.

The adjuster also has many other tools available to investigate claims, to include obtaining an attorney to depose the injured worker under oath and inquire as to the facts of the injury, to see whether or not that is consistent with the employer's version.

The adjuster could also conduct some surveillance on the injured worker to see if the injured worker is doing activities that would suggest the injury is not legitimate.

The adjuster could also run an activity check on the injured worker, inquire with the neighborhood as to the applicant's activities, run a civil and criminal background check, and check the applicant's driving record. Again, there is much to do in the 90-day period that could be vital to determining whether to accept or reject a claim. As a result, those activities must be undertaken immediately, given that the 90-day period will run very quickly.

The main lesson to learn is to report injuries timely and identify suspicious claims, so that the 90-day period could be used to accept or reject a claim timely.

TREATMENT ISSUES

If a claim of injury is admitted, the employer input is still vital on the claim. Again, reporting the injury timely is very important under these circumstances as well, in the fact that under the Labor Code, under some circumstances, the employer has 30 days of medical control over a claim. Those 30 days are the time from when the claim is first filed and on. Therefore, reporting claims timely, so that the adjuster can take full advantage of the 30-day control can be very important to the case.

Medical control has become very important in Workers' Compensation, as medical control allows the insurance carrier to choose the doctors of their choice, whom they trust and in whom they have confidence in treating the injured worker, as opposed to a self-procured doctor who is more than likely to treat more than is needed.

Taking full advantage of that 30-day treatment and control can be very important in the life of a Workers' Compensation claim.

Thereafter, even if the control is taken away, the ongoing employer's involvement in treatment issues can be helpful and useful in defending a Workers' Compensation claim. During the lifetime of a medical treatment claim, the injured worker at various points will be allowed to return to work on modified duties or regular duties. It is at these points and time that the employer's input must be provided. Specifically, if the injured worker is allowed to return to work with modifications, the employer not only must address whether they can offer those modifications, but also whether they could adhere to those modifications during the entire period necessary.

Returning an injured worker to work is always a positive, given the fact that you will no longer be paying temporary total disability benefits, and hopefully the injured worker will be of some use and allow his employer to keep an eye on the injured worker.

However, if an injured worker is allowed to return to work with restrictions, those restrictions must be adhered to. Failure to adhere to those restrictions can result in the applicant's claim of injury worsening, requiring additional treatment and the possibility of a new injury, but also raises the possibility of a Serious & Willful Misconduct claim if an employer is found to be grossly negligent in not adhering to work restrictions.

Therefore, an employer must not only be made aware of the restrictions given and the definition of the restrictions given, but also must be made aware of the timeframe required to adhere to those restrictions. Therefore, constant involvement with the injured worker and the adjuster and the employer is required, even on admitted injuries.

EMPLOYER'S INVOLVEMENT WHEN AN INJURED WORKER REACHES MAXIMUM MEDICAL IMPROVEMENT

During the pendency of a Workers' Compensation claim, there is a point where the injured worker has reached a plateau in his treatment. Essentially this is the point where the applicant's treatment has rendered the applicant with Maximum Medical Improvement (MMI) or is found Permanent and Stationary. When that level has been reached, the question then is raised as to whether the applicant can be allowed to return to work.

The question this time, however, is quite different from that when the applicant was treating. When the applicant is treating the restrictions are on a temporary basis and the employer can either provide work within the restrictions or not. It is simply up to the employer. The upside to returning the injured worker to work of course is not paying benefits and hopefully having a productive worker. The downside of course is paying TTD. However, when the applicant reaches MMI level, the question now becomes much more important.

It is at this point and time when the applicant has reached Maximum Medical Improvement that the inquiry is now whether or not you can return the applicant to work on a permanent basis. Under Workers' Compensation, that means 12 months or more, but under the

ADA, can be more far reaching. The issue again is whether or not you are able to return the injured worker to work within the restrictions given by the primary treating doctor. That inquiry, under prior circumstances, was an inquiry that had little downside. Essentially, if an injured worker were not wanted back, you would simply put the applicant through rehabilitation and be done with him. Now, with rehabilitation now being eliminated by SB 899, the consequences of saying that the employer does not have alternate or modified work results in an unemployed worker. That unemployed worker then may look into other areas of law to litigate that decision to include disability discrimination and ADA. Thus, the employer's input on that issue becomes vital. Specifically, the employer's input as to whether or not you can return an injured worker within the restrictions to an alternate or modified position is the inquiry that must be made in good faith, regardless of how you feel about that injured worker. Under the ADA, the employer must look for reasonable accommodations for the employee to return to work.

SUMMARY

As you can see, the employer's role in Workers' Compensation has increased over the last 15 years. Now, at every step of a Workers' Compensation claim an employer's input is necessary. The more proactive the employer, the more likely you will be able to successfully handle Workers' Compensation claims, reduce your costs and avoid ongoing claims. If you can successfully pay only the claims that are legitimate and dispute the claims that are not, within the timeframes and the scope of the Labor Code, your Workers' Compensation premiums, costs and litigation should all be well under control. However, without that proactive employer input, Workers' Compensation becomes very difficult and many claims are then paid that should not be paid, settlements are made that should not be made, medical treatment is provided that should not be provided, and costs and expenses and insurance premiums all begin to skyrocket. Don't' let that employer be you.

SB 899
THE COMPREHENSIVE REFORM OF THE CALIFORNIA WORKERS' COMPENSATION SYSTEM AND ITS IMPACT… SO FAR

On April 19, 2004 the California Workers' Compensation System was overhauled from beginning to end. Governor Schwarzenegger made a promise to the State of California that if elected he would reform the System, so that California would become more employer-friendly.

Prior to SB 899, the Workers' Compensation System was full of fraud and skyrocketing expenses, with increased premiums, and many businesses felt they could no longer do business in California due to the Workers' Compensation System alone.

In practice, Workers' Compensation became very applicant oriented, with the advent of the treating doctor presumption and 30-day medical control issues. As a result, more cases were litigated, litigation costs were also skyrocketing and Awards were given at amounts three to four times what was previously provided in the System.

To put an end to this abuse, SB 899 was enacted within four months of Governor Schwarzenegger's election as governor and SB 899 overhauled the entire System from beginning to end.

Overall, statistics for the first three years of the new System show conclusively that cost savings have been achieved.

The following is an analysis of specific benefits of Workers' Compensation, and how they have changed by SB 899 and its impact so far.

1. Medical Treatment:

Medical treatment was one of the major problems in Workers' Compensation prior to SB 899. Medical treatment, especially in the Los Angeles area, was out of control due primarily to the fact that the applicants took full advantage of the treating doctor presumption law. Allowed to select their own doctors after 30 days, they selected doctors who became bolder and bolder in their prescriptions of treatment of the injured workers, given this presumption of correctness. With home health care, gym memberships, housekeepers, orthopedic mattresses, home alterations, and sometimes even vehicles being prescribed and authorized, and having those prescriptions being rather commonplace, treatment expenses skyrocketed through the 1990's and early 2000's.

SB 899 put a stop to all of the abuse for the most part by enacting into law the Medical Provider Networks, which provided employers with control of medical treatment during their entire pendency of the claim, and, more importantly, ACOEM Guidelines for treatment.

California placed into effect a system whereby any treatment recommendations or plan by a treating doctor would have to be reviewed by the carrier utilizing the ACOEM Guidelines as being a presumptive correct method of treating injured workers. Any treatment plan outside of the ACOEM Guidelines would have to be argued by a physician with Utilization Review and certified only on the most rare of circumstances when that injured worker's circumstance was somehow different and extraordinary. For the most part however the utilization of ACOEM Guidelines and Utilization Review, coupled with the Medical Provider Network reduced treatment costs substantially. We believe that prior to SB 899, the State of California reached an all-time high of $8 billion spent in medical treatment costs. In 2006, those costs were reduced to $3.8 billion, and those costs are continuing to decrease.

2. Temporary Total Disability:

SB 899 enacted legislation that reduced the period of TTD benefits from a five-year maximum to a two-year maximum. Essentially an injured worker could only obtain TTD benefits from an injury after April 19, 2004 for 104 weeks or a two-year period. Again, this legislation was placed into effect to reduce costs and has effectively reduced many claims, especially now. We are now well past the two-year mark, and many Claims

adjusters have cut off TTD benefits simply because of the new law. Anticipated savings, as a result, should be analyzed shortly, but clearly cost will be reduced based on this limitation.

Just recently, the law was further amended to now allow for two years of TTD, but over a five-year period, instead of two years, but still there is only a 104-week maximum of benefits provided.

3. <u>Permanent Disability:</u>

Permanent disability took the biggest hit in Workers' Compensation. Actual savings due to the SB 899 legislation in permanent disability ranged from anywhere from 40% to 66%. Essentially, prior to SB 899 permanent disability was valued based on work restrictions and subjective factors of disability. With the treating doctor presumption, a doctor could give an opinion on work restrictions that would be required for an injured worker to return to work that would be presumed correct. Those opinions, because of the presumption of correctness, became more and more outrageous in their findings and, as a result, disability levels increased. With no guidelines in place in reference to permanent disability, this was another area of Workers' Compensation that was full of abuse prior to SB 899.

SB 899, when enacted, however, changed the entire system of evaluating permanent disability. Now, SB 899 provides that permanent disability should be based on whole person impairment under the AMA Guides. This is an objective based system that is based on statistics, science and objective factors in determining the levels of disability.

No longer is a subjective factor a major criteria in evaluating disability. As a result, the levels of disability for work injuries drastically dropped. Further reducing the levels of permanent disability was SB 899's enactment of new legislation pertaining to apportionment. Now, apportionment is to causation, rather than disability. Prior to SB 899, this apportionment to prior injuries, impairment or restrictions was quite difficult to obtain, in light of the fact that you must show not only a prior injury, but also a prior <u>disability</u> to effectively have a chance at proving apportionment. Now, the criteria is causation, as opposed to disability, which is a much easier argument to be made. Furthermore, apportionment to causation as opposed to disability complies with the overall legislative intent that an employer should only pay for the disability stemming from their industrial injury only.

Furthermore, SB 899 also enacted legislation that conclusively presumes that a prior injury and level of disability was conclusively presumed to be present at the time of your industrial injury.

These two apportionment laws further reduced the PD values of cases, plus SB 899, resulting in tremendous savings to employers and carriers.

4. Vocational rehabilitation:

Vocational rehabilitation was essentially wiped out in the sweeping legislation of SB 899. Now, injured workers are entitled to vouchers, which in practice are very rarely used, and thus tremendous savings have been reached in reference to vocational rehabilitation post SB 899.

5. Return To Work Discount:

Employers are now able to obtain a 15% reduction in Workers' Compensation permanent disability awards if they are able to return the injured worker to alternate, modified or regular work following the industrial injury. Those that have taken advantage of the discount have achieved further savings as a result. The contrary, however, is also present in that if an employer cannot take an injured worker back to work, the 15% increase in permanent disability may be available.

WORKERS' COMPENSATION IN THE FUTURE

Although SB 899, so far, has been hugely successful in streamlining medical treatment, reducing costs and making Workers' Compensation a much more affordable system for California employers, that is not to say that the sweeping reforms and changes will not be attacked. Currently, there is a plan of attack that is being brought forth by the Applicants' Attorneys Bar to essentially limit the affects of SB 899. Medical treatment issues are being attacked on a daily basis, as UR decisions and the applicability of ACOEM Guidelines are being attacked on a daily basis. Certification requests that have been denying treatment have been routinely objected to by applicant attorneys, resulting with the parties proceeding with an Agreed Medical Evaluator or a Qualified Medical Evaluator to resolve the issues.

Furthermore, the MPN is being attacked as well, by adding doctors to the MPN List that are friendly to injured workers or, in the alternative, attacking the MPN System itself, by arguing that the Network does not comply with the Rules and Regulations in providing specialists.

Temporary disability issues are also highly litigated, given the fact that benefits are being cut off. Creative attacks include attacking the exceptions to the two-year rule that recently resulted in a decision in reference to the exception of amputations.

Permanent disability benefits have been reduced the most and, therefore, have been attacked the most, given that applicant attorneys garner most of their fees from a percentage of the permanent disability award.

To that end, there have been attacks across the board on permanent disability to include the applicability of the AMA Guides to existing injuries, the exceptions to the rule allowed by Labor Code Section 4660 and adding additional body parts to the claim to make up for the different lost in using the AMA Guides as opposed to work restrictions.

Furthermore, there has been a strong attack against all of the apportionment laws, but for the most part defendants have prevailed on these issues.

We do anticipate more litigation, however, as a result of the large reduction in expenses, costs and indemnity due to SB 899, but in summary, SB 899, so far, has been a great success in providing a Workers' Compensation System that is far more manageable and feasible for the California economy.