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REVIEW OF WORKERS' COMPENSATION BENEFITS

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CALIFORNIA ASSOCIATION OF HIGHWAY PATROLMEN

BY: SCOTT A. O'MARA

I. WORKERS' COMPENSATION BENEFITS

A. Definition of Injury

Two types of injuries are recognized In the Workers' Compensation System: specific injuries and cumulative trauma injuries.

A *specific injury* is an injury which results from a specific event occurring on a particular day at a particular time. Some examples of specific injuries include a broken ankle suffered in a vehicular collision; a deep cut on the arm caused by an altercation with an unruly person; or a muscle strained while lifting debris from an accident scene.

On the other hand, a *cumulative trauma ("CT") injury* is not an injury which results from one specific event, but rather an injury which results from continuous or repeated trauma over a period of time. This cumulative trauma causes unusual wear and tear on a particular part of the body, resulting in such problems as hearing loss, heart problems, hypertension, lung problems, an emotional condition, blood borne pathogens, orthopedic injuries, cancer and/or other conditions, such as neck, back, knee and shoulder injuries. While CT injuries can be more difficult to substantiate than specific injuries, they are nonetheless recognized by the courts as true job-related injuries with the same entitlement to benefits as specific injuries.

To be approved, a work-related injury claim must prove that factors of employment *caused, aggravated or contributed* to the development of the condition. If a condition existing before employment is made worse by a worker's job activities, that condition could be considered work-related and the employee would be entitled to benefits under the Workers' Compensation system. Also the ancillary injury could be job related. (Newsletter 2023, Issue #12)

After the court orders an award of permanent disability for the injured worker, the worker has five years from the date of injury to obtain more justice if the level of disability increases during this period of time. The Labor Code allows for the increase of disability if a petition is filed timely within the five year period of time from the date of injury to reopen the case for new and further disability. *(For more information, see* www.LAW1199.com Newsletter 2021, Issue #6)

***(For more information, see* www.LAW1199.com Newsletters 2015, Issue #6 regarding specific and cumulative trauma injuries; and 2016, Issue #11 regarding your privacy rights.)**

B. Rebuttable Presumptions

The rebuttable presumption is job-related for specific safety officers, including CAHP members, and includes heart trouble, pneumonia, hernias, Lyme disease, tuberculosis, blood borne infectious diseases, injuries caused by biochemical substances, meningitis, back injuries, cancer, and Post Traumatic Stress (PTSD). Rebuttable presumption allows the employer to deny the injury if Proper Facts are not developed and presented. This requires the worker to understand and inform the doctor of actual and possible exposures in his/her work. With presentation of proper evidence, these presumptions are helpful, although they can be rebutted. Other body parts or systems not officially designated as falling within the presumptions may still benefit from the presumptions if a change in the non-designated system or body part has impact on a presumed body part or system. For example, while hypertension alone is not presumed job-related, it can fall within the heart presumption if certain fact patterns exist. *(See* www.LAW1199.com Newsletter 2023, Issue #12. For additional information on other rebuttable presumptions, see Newsletter 2020, Issue #1 [Awareness of PTSD] and 2019, Issue #12 [Passage of S.B. 542 regarding PTSD].)

Employers knowledge of injury 90-day rule or 75-day rule and after 75-day rule (Hernia, Heart, Pneumonia, P.T.S.D., Back, Cancer, Biochemical Exposures, Meningitis, Lyme Disease, Blood Borne Infections, Labor Code §3212 — §3212.85, §3212.9 — §3213.2).

***(For more information, see* www.LAW1199.com Newsletter 2015, Issue #2 regarding the history of presumptions, Presumption PTSD extended to 01/01/2029, 2023, Issue #11).**

C. Benefits

Legislation related to the Workers' Compensation System provides a range of benefits to assist workers and their dependents. These benefits include salary continuation for CHP Officers members under Labor Code §4800.5, temporary total disability payments, permanent disability indemnity, medical care, supplemental job displacement benefits, death and burial allowances, and mileage expenses.

D. Temporary Total Disability (TTD) and Labor Code §4800.5 Benefits

1. Temporary Total Disability (TTD) Benefits (Non-Sworn Employees& CHP Officers)

The level of TTD benefits depends upon the date of injury. Typically, temporary disability benefits are two-thirds of your weekly earnings tax-free with a maximum. For 2026, the maximum TTD $1,764.00 per week.

2. Labor Code §4800.5 Benefits/Limitations – (CHP Officers)

Labor Code §4800.5 entitles safety officers to receive up to one year of your full salary tax-free if you are off work due to a job-related injury which precludes you from being able to

perform your substantial duties, and a light-duty job is not offered to you which accommodates your Workers' Compensation limits.

a. Single or Specific Injury — In the case of a single or *specific injury*, Labor Code §4800.5 salary continuation is payable if you are off work, whether temporarily or permanently disabled.

b. Cumulative Trauma/Cumulative Injury — Labor Code §4800.5 benefits payable to CHP safety members whose disability is *solely* the result of *cumulative trauma* or *cumulative injury* are limited to *the actual period of temporary disability* or one year, whichever is less.

Total payment of TTD and Labor Code §4800.5 benefits are not to exceed 104 weeks from the date of injury.

E. Medical Care

The worker has the opportunity to protect himself/herself by designating their personal treating physician who has examined the worker for treatment and reviewed same prior to sustaining an industrial injury (DWC Form 9783). Medical care provided through Workers' Compensation is extensive. Benefits include, but are not limited to, hospitalization, surgery, doctor's care, doctor consultations, lab fees, prescriptions, physical therapy, psychiatric treatment, prosthetics, nursing home care, transplants (*e.g.*, liver or heart), special orthotics for shoes, and potential modifications of the injured worker's house to accommodate his/her ability to move around the residence.

The determination as to the need for care to cure is based upon several factors. One is the doctor's opinions and findings regarding the job-related injury. The physician's evaluation will be based upon his or her examination of the patient, as well as statements made by the patient as to pain and discomfort and/or restrictions they believe they have — which are referred to as subjective complaints.

In addition, the evaluating doctor will use objective findings — based upon an x-ray, MRI, EKG or other objective testing, such as the configuration of blood drawn from the patient, or elements found within a urine sample.

The injured worker's description of subjective complaints is a significant element in the determination as to the type, necessity and length of care which may be needed. These complaints can have substantial importance in the doctor's determinations regarding these factors . . . as well as the credibility of the worker.

Injured workers must realize that these are not cavalier statements. They are statements which can impact their care and their access to same — potentially throughout their lifetime.

Prior to meeting with a physician, an injured worker should give some thought and preparation as to their subjective complaints to make sure the characterization they give provides a broad spectrum as to what they are experiencing relative to any restrictions, limitations, discomfort, etc. (Law1199 – 2019 #4 / Law1199 – 2019 #8).

Regarding subjective complaints (other than extreme medical problems), injured workers may have times when they have good days and bad days. Articulating this fact — if it is accurate — will support the credibility of the worker, as opposed to the worker who only wants to articulate their pain and discomfort without acknowledging that they have times when they are doing better.

Many eyes will always evaluate the concept of subjective complaints, which will be considered not only by an injured worker's primary doctor, but also any secondary doctors who may be called in to review an ancillary problem, as well as any nurse case managers and adjusters. Therefore, a worker's subjective complaints can prove to be paramount as to their perceived credibility, as well as their access to — or denial of — medical care.

A threshold issue that must be dealt with is utilization review by a doctor selected by the employer to determine the appropriateness and necessity of recommended medical care. *If you treat with a doctor who is a patient advocate, that physician will assist you in obtaining the medical care that is necessary.* (*See* www.LAW1199.com Newsletter 2022, Issue #11 Balanced Communication with the Doctor). Utilization Review (UR), which commenced 04/19/04; and Independent Medical Review (IMR), which commenced 01/01/13. *(See* www.LAW1199.com Newsletter 2019, Issue #3 for proposed changes, and Newsletter 2021, Issue #3 regarding A.B. 1465.)

Medical care for a non-work related condition can be the responsibility of workers' compensation if the condition makes the work-related condition worse. (*See* www.LAW1199.com Newsletter 2023, Issue #9).

The overview of the damage medical care access is stated in the attached APB Article of July 2015, Volume 42, No.: 7.;

(For more information on this subject, see www.LAW1199.com Newsletter 2014, Issue #1 regarding the secretive process; 2015, Issue #10 regarding review of medical care; and 2016, Issue #9 regarding UR doctor accountability.) (Health, dental and vision benefits: (1) Vesting — date of hire before 1/1/85; (2) Vesting — date of hire after 1/1/85; (3) CAHP Benefits Trust; APB May 2018, Volume 45, Number 3, page 17. For a New Medicare Card, go to APB May 2018, Volume 45, Number 3, page 5.)

F. Permanent Disability

Awards of monies for permanent disability are based upon the residual impairment occurring as a result of a work-related injury or illness. The medical evidence obtained from the Treating Physician, Agreed Medical Evaluators and/or Qualified Medical Evaluators determines a worker's impairment. Permanent disability is then expressed as a

percentage determined by a formula incorporating the medical impairment adjusted for occupation and age at the time of injury. Level of permanent disability does not determine if the officer can or cannot continue to work or needs to retire.

Workers unable to return to their jobs because of a work-related injury may also be eligible for a vocational rehabilitation voucher worth up to $6,000 for schooling. Senate Bill 863 also created a $120 million fund to enhance permanent disability benefits for workers whose permanent disability benefits are disproportionately low in comparison to their loss of earnings. This fund enables injured workers to receive up to $5,000 for job displacement in addition to the $6,000.00 voucher. *(For more information on this subject, see* www.LAW1199.com Newsletter 2013, Issue #4.)

G. Death Benefits

Death benefit allowances can range up to $320,000.00 or more, depending upon the number of dependents and their ages, as well as other factors. The maximum reimbursement for burial expenses currently is $10,000.00. Additional benefits beyond $320,000.00 are available if there are children up to the age of 18, or if a child is incapacitated. Entitlement to a scholarship may also be available pursuant to Labor Code §4709.

H. History of the California Workers' Compensation System

The California Workers' Compensation system has evolved considerably since the first enactments in the years 1911 and 1913. The foundation for the California system emanated largely from the industrial revolution which occurred in the 1900s, first in Europe and then in the United States. At that time, awareness developed that *as a cost of doing business; employers need to provide benefits to workers who sustain job-related injuries.*

The first legislative enactment was the Roseberry Act of 1911, which provided a voluntary plan of compensation. This act was followed by the Boynton Act of 1913, which replaced the voluntary plan with a compulsory plan. Employers and workers entered into an agreement whereby workers were restricted as to their routes for indemnification, and a so-called "no-fault" system was created — *i.e.*, a system in which the worker was not required to demonstrate that the employer was at fault for a job-related injury. The goals of these early enactments were to provide California workers: the medical care they needed to cure or relieve the effects of their injuries; adequate income during their recovery period; and economic recognition for any permanent disability or impairment remaining after their period of treatment.

In 1970, the Federal Government enacted the Occupational Safety & Health Act, known as OSHA, which promulgated minimum rules for a safe work environment.

Finally, in 1975, legislation was enacted which allowed injured workers who could no longer continue with their employment a protocol for vocational rehabilitation so they could successfully re-enter the labor market. Of great significance also was the fact an injured employee could select his/her own physician 30 days after the date of injury. In

addition, this legislation established the requirement for employers to give workers notice of their Workers' Compensation rights, and payments for life to workers totally disabled and unemployable as a result of a job-related injury.

Additional changes were made in 1989 and 1993, and *substantial changes occurred in 2004 and 2012, causing considerable harm to many injured workers*. In September 2012, Senate Bill 863 was enacted. Some of the changes introduced by this bill are positive, *but there are some very harmful consequences, such as IMR, the cloak of secrecy, and the lack of judicial review*.

In the meantime, the population of California has grown to nearly thirty nine million and thousands of whom have sustained job-related injuries. An awareness of how the Workers' Compensation system works is paramount for all workers to protect themselves and their families.

***(For more information, see* www.LAW1199.com Newsletter 2014, Issue #1 regarding the secretive IMR process; 2014, Issue #2 regarding the harm to workers; 2014, Issue #3 regarding the negative impact of SB 863; 2019, Issue #3 regarding proposed legislation to correct the wrongs of SB 863; and 2021, Issue #3 regarding proposed legislation to protect some of the wrongs regarding access to medical care.)**

I. Federal Benefits (PSOB)

The Public Safety Officers' Benefits (PSOB) program — a Federal program administered by the Department of Justice — provides the potential of a one-time lump-sum payment to the survivors of a deceased safety officer whose death has resulted from a line-of-duty incident, such as a heart attack, stroke or vascular rupture. This program also provides benefits — again, a one-time lump-sum payment — to safety workers permanently prevented from doing their work in law enforcement and engaging in other gainful employment. The PSOB program also provides some assistance to help the spouses and children of deceased or permanently injured and unemployable safety officers participate in higher education.

II. RETIREMENT BENEFITS

By: Scott A. O'Mara

A. CalPERS State Safety Members/Non-Safety Members

1. California Highway Patrol officers are state safety members of the California Public Employees' Retirement System (CalPERS). In addition to "normal" or service retirement, if you become disabled from performing your job duties, either physically or mentally, you may be eligible for disability retirement benefits. Government Code Section 20026 defines "disability" and "incapacity for the performance of duty" as a basis for retirement, meaning disability of permanent or extended duration, which is expected to last at least 12 consecutive months or will result in death, as determined by the board, or in this case of a

local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion. CalPERS has the right to have the member evaluated by an Independent Medical Examiner of their choosing, in determining whether or not the member is substantially incapacitated under the meaning of Government Code 20026. As a safety member, you may be eligible for industrial disability retirement benefits if your disability resulted from a job-related injury or illness, regardless of age or years of service (WCAB determines if condition is job-related for retirement). There is no age or years of service vesting requirement for Industrial Disability Retirement and benefits.
Officers retired for industrial disability before age and service eligibility are subject to reevaluation by CalPERS to determine if they continue to be incapacitated. The Government Code requires reinstatement when recipients of disability retirement are no longer incapacitated by the condition for which they were retired.

In the *California Department of Justice v. CalPERS, Angelita Resendez*, the Court held that a peace officer who is subject to mandatory reinstatement from disability retirement by CalPERS cannot be subjected to conditions by the employer or required to undergo a fitness-for-duty evaluation. This applies to CAHP safety members.

2. Non-Safety Member

Non-Safety members are eligible to apply for a Disability Retirement (DR) with CalPERS when there is a showing of inability to perform the usual job duties, due to an injury or illness regardless of the origin of injury (Disability Retirement does not require the acceptance of a workers' compensation claim). The vesting requirements vary based upon your tier. Tier 1 must have 5 years of credited service. Tier 2 must have 10 years of credited service. There are no age requirements to apply. Generally, the benefit for a disability retirement is 33% of an average of your last 18 months earnings. CalPERS is able to generate an estimate to give an exact figure.

B. Actual vs. Prophylactic Work Restrictions

For disability retirement purposes, restrictions must be *actual*, not *prophylactic*. In fact, the CalPERS disability application states: *"Prophylactic restrictions are not a basis for a disability retirement."* If the employer can accommodate prophylactic restrictions, the worker can potentially continue with his or her career.

The pivotal case involving the CalPERS retirement system and setting forth this issue is *Willie Starnes v. Department of California Highway Patrol*. In this case, Sgt. Starnes wanted to return back to work, but the CHP refused to take him back, even though his restrictions were prophylactic. I successfully litigated this case, which is considered to be of *precedential* value because it reinforced the concept that *actual* restrictions are the standard necessary to either obtain or be forced into a disability retirement, and *prophylactic* restrictions are not a sufficient basis for retirement in either scenario.

C. Time to File for an Industrial Disability Retirement

The time for a state safety member of CalPERS to file an application for industrial disability retirement as set forth in Government Code §21154 are while you are:

- **Working for a CalPERS-covered employer; or**
- **Within four months of discontinuation of service with the employer; or**
- **Continuously disabled from the date of discontinuance of service to the time of application for Industrial Disability Retirement; or**
- **Absent on military service.**

D. Presumptions of Industrial Causation for Safety Member Disability Retirement

Many safety members suffer significant disability and death from cancer or heart trouble. Recognizing the significant exposures and inherent stress associated with law enforcement and public safety employment, the CalPERS system provides that certain injuries might be presumed to be work-related. This is a rebuttable presumption requiring proof of particular facts.

The Government Code has provisions for retirement which mirror some of the presumptions of causation under the Labor Code for Workers' Compensation purposes:

1. **Heart trouble. (Gov. Code §31720.5) *(Requires completion of 5-years of service.***
2. **Cancer. (Gov. Code §31720.6) *(Requires completion of 5 years of service.)***
3. **Blood-borne infectious disease or MRSA. (Gov. Code §31720.7)**
4. **Illness due to exposure to a biochemical substance. (Gov. Code §31720.9)**

E. Determination of Causation and Incapacity

There are two key elements in establishing eligibility for an Industrial Disability Retirement: *causation*, that the disabling injury or illness is work-related; and *incapacity*, that due to work-related injury or illness you can no longer perform the substantial duties of your job.

For state safety members of CalPERS, upon completion of an application package for industrial disability retirement, CalPERS will review the file for completeness and current information. The determination of incapacity is made by CalPERS, while causation of disability is made by the Workers' Compensation Appeals Board. (*Do not give up your right*

***to return to work if granted disability retirement and your condition improves allowing you to return to work.*)**

F. Calculation of an Industrial Disability Retirement Allowance

Government Code §21411 provide:

> **Upon retirement of a state safety member for industrial disability he or she shall receive a disability retirement allowance of 50 percent of his or her final compensation plus an annuity purchased with his or her accumulated additional contributions, if any, or, if qualified for service retirement, he or she shall receive his or her service retirement allowance if the allowance, after deducting the annuity, is greater.**

Under provisions of the Internal Revenue Code, the disability retirement allowance of 50% of final compensation is excluded from gross income for Federal income tax purposes, *i.e.*, non-taxed.

***(For more information on retirement, see* www.LAW1199.com Newsletter 2017, Issue #1 regarding the Distinction Between Actual and Prophylactic Restrictions; and 2015, Issue #3 regarding Retirement Considerations and www.LAW1199.com 2023, Issue #10 Time Limit to Obtain a Disability Retirement.)**

III. THIRD-PARTY AUTO ACCIDENT CASES AND UNINSURED/UNDERINSURED MOTORIST COVERAGE

By: Scott A. O'Mara

Recovery in a third-party lawsuit is dependent upon a third party's negligence. A third party is anyone other than your employer or a co-worker. A civil action against a third party requires evidence of negligent conduct by that party; evidence of injury caused by the third party's action; and evidence of damages incurred, including medical expenses, wage loss, and/or pain and suffering.

A. Third-Party Cases v. Workers' Compensation Cases

Third-party auto accident cases and Workers' Compensation cases are different in that *recovery is potentially unlimited in third-party cases*, whereas recovery in Workers' Compensation cases is subject to some limitations. Also, a third-party case may have connection to a Workers' Compensation case, or it may be entirely separate and distinct. A connection exists when the third-party case results from an injury caused by the third party during the course and scope of a member's employment.

Regardless of whether an employment factor exists, a third-party auto accident civil action must be brought within two years of the date of injury. If the claim is against certain governmental agencies, additional time limitations may apply, ranging anywhere from 100

days to six months. If the negligent third party is uninsured or underinsured, and the injury is the result of an auto accident, you still may be able to file a claim for damages against that party if you have purchased uninsured/underinsured motorist coverage.

B. Uninsured/Underinsured Motorist Coverage

The "Uninsured Motorist Act", Section 11580.2 of the Insurance Code of the State of California, requires every automobile liability insurance policy issued in the State of California to include uninsured/underinsured motorist coverage. This coverage is designed to compensate the insured for bodily injury caused by a financially irresponsible motorist. An uninsured motorist is one who has no insurance; an underinsured motorist is one who has liability insurance against the insured's claim, but its limits are insufficient to fully compensate the insured. ***(Hereinafter, "uninsured/ underinsured motorist coverage" is referred to simply as "U/UM coverage".)***

U/UM coverage is perhaps the single most important coverage in your automobile insurance policy. **It applies when bodily injury is caused by a vehicle driven by a motorist who has little or no insurance. The purpose of U/UM coverage is to ensure that motorists injured by financially irresponsible drivers are protected to the extent they would have been protected had the driver at fault carried liability insurance.**
Please note that U/UM coverage is only required to be offered in primary automobile liability policies. It is not required for excess or umbrella policies, unless specifically endorsed into such a policy. An excess or umbrella policy is a liability policy which goes over your primary automobile policy. You must check with your agent and read your policy to determine whether U/UM coverage has been endorsed into any excess or umbrella policy you may have.

The "named insured" is the individual identified on the declarations page of the policy as the "insured." This individual is covered. In addition, the following persons are also considered insured for purposes of U/UM coverage:

1. **The spouse of the named insured.**
2. **Relatives of the named insured, if they are residents of the same household.**
3. **Any other person present in or upon the insured vehicle.**

If an insured is killed by a U/UM driver, the heirs entitled to maintain a wrongful death claim become beneficiaries to the U/UM coverage. The term "other persons" considered insured for U/UM coverage include guests or other users of the insured vehicle with the express or implied consent of the named insured.

U/UM coverage is relatively inexpensive given the breadth and scope of the protection afforded. The general recommendation is that you buy as much U/UM coverage as your budget will allow, and that you shop around, as each insurer has limitations on how much U/UM coverage they will sell. Because of the offsets for Workers' Compensation, as well as the reduction for recovery from the adverse motorist, you should procure coverage not less than $1,500,000.00 (and even higher limits when possible) to have a reasonable measure of

security that your claim will be fairly compensated. In a scenario where you suffer a career-ending injury, you more than likely will need coverage between $1,500,000.00 and $5,000,000.00 to be adequately protected.

Every insurer who sells automobile insurance in California sells U/UM coverage, and, pursuant to the Insurance Code, every insurance policy is essentially the same. However, differences do exist in the premium charged and the limits of coverage the carrier will sell. Therefore, you should shop on an annual basis to obtain the best premium and the highest limits your budget will afford relative to your needs.

Once you have determined that you have been harmed by an uninsured or underinsured motorist, you should immediately notify your insurance company that you have a potential claim under your U/UM policy. You will need to prove you were harmed by an uninsured or uninsured motorist, and you and your insurer will need to agree upon the value of your bodily injury claim. Your insurer will then begin to evaluate your claim as though they were the insurer for the adverse motorist. The benefit to you in this environment is that your insurer has a fiduciary duty to treat you in good faith promptly and fairly, and pay you reasonable value for your claim.

One precondition to establishing recovery under U/UM benefits is to show that the U/UM driver was negligent in the operation of a motor vehicle which caused bodily injury to the insured. If the accident proves to be your fault, or you have some contribution in causing the accident, you will then receive no recovery, or your recovery will be reduced commensurate with your percentage of fault.

Note also that you do not have to be in your insured vehicle to have a U/UM claim.

Regarding U/UM coverage, the Workers' Compensation system and the retirement system *do not have subrogation rights* in this scenario, although subrogation does exist in many other third-party recovery actions outside U/UM coverage. Subrogation allows the employer to receive either full or partial reimbursement for monies expended relative to medical care, permanent impairment and/or industrial leave/ §4800.5 time, or payments of temporary total disability.

Subrogation recovery depends upon the nature of the injury, the likelihood of success and the mechanics of the injury, along with any liability the employer may have. In some situations, because of the limits of liability, there may be a complete offset for many benefits received from a third-party case in which the employer has reimbursement rights. This again emphasizes the strong necessity for purchasing U/UM coverage to protect you and your family.

***(For more information on this subject, see* www.LAW1199.com Newsletter 2017, Issue #3 for an overview of U/UM coverage.)**

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TYPES OF INJURIES: SPECIFIC AND CUMULATIVE

BY: SCOTT A. O'MARA

In Workers' Compensation, the Labor Code defines two types of injury — *specific injuries*, which occur at a particular place and time from one event (such as injuries resulting from a fall or a vehicular accident); and c*umulative trauma injuries*, which result not from one specific event, but from a combination of activities or exposures over a period of time (such as cancer resulting from carcinogenic exposures, orthopedic injuries resulting from repetitive physically demanding activities, hearing loss due to repetitive noise exposure, or heart disease resulting from sustained stress). A cumulative trauma injury is akin to the bending of a paper clip. If you bend it back and forth enough, it will break — not immediately, but eventually. The breakage will result not from one bend, or several bends, but from the combined effect of repeated bending over a period of time.

Both specific injuries and cumulative trauma injuries — once they have been established as being work-related — create an entitlement for the injured worker to receive benefits. However, the employer has a litany of tools which can be used to deny a job-related injury, such as the statute of limitations, which defines a limited window of time within which the injured worker must seek relief from the effects of a job-related injury — whether it be in the form of medical care, pay for time off work, permanent disability benefits, or other relief — or else forfeit the opportunity to receive such benefit.

Once the worker is aware that he or she has sustained a job-related injury, the statute of limitation takes effect. Typically, this limited window for seeking relief is a one-year period of time. Depending upon the particular circumstances of a case, this period could be one year from the date of injury, or the date of initial knowledge of an injury; one year from the date medical care was last received; or one year from the date of last payment of Labor Code §4800.5/§4850 or temporary disability benefits.

There are certain aspects of employer conduct which may toll the statute of limitations, but injured workers are strongly encouraged to file a Claim Form when any type of work injury has been sustained. Labor Code §5400 states specifically:

"Except as provided by sections 5402 and 5403, no claim to recover compensation under this division shall be maintained unless within thirty days after the occurrence of the injury which

is claimed to have caused the disability or death, there is served upon the employer notice in writing, signed by the person injured or someone in his behalf, or in case of the death of the person injured, by a dependent or someone in the dependent's behalf."

If the employer can claim prejudice, or claim being misled, within 30 days of the filing, the employer can seek dismissal of the claim.

With these guidelines embedded in the system, the employer wants to be able to conduct a timely and reasonable review of the claim. The longer the time from the date of injury or filing, the more difficult is the process for the employer.

In essence, based on the rules which exist, any worker who sustains an injury or condition which he or she knows or reasonably believes is job-related should file a timely Workers' Compensation claim to protect his/her rights related to this matter.

A study has been published regarding safety officer claims in Los Angeles, but the results from the audit review and summary are being taken out of context in an attempt to take issue with the claims being filed. The study reviewed the claims of 9,983 peace officers and 3,246 firefighters — two safety groups which together comprise 28% of the City's labor force — and the audit noted that these groups accounted for more than 60% of the Workers' Compensation cases. However, those figures do not take into account the unique exposures to harm which police and fire personnel have, nor does it acknowledge the valuable front-line role these safety groups play — like soldiers in a war zone — in defending and protecting the public from criminal activity and potentially disastrous situations. To put safety personnel in the same category as other labor groups is disingenuous, uninformed and totally without substance, yet there is some discussion regarding same.

The study further noted that in Los Angeles the claim ratios for safety personnel are 31.7 per 100 police officers, and 37.1 per 100 firefighters. These numbers are compared with those in other cities, including San Diego, where these same claim ratios are 24.7 per 100 police officers, and 29.4 per 100 firefighters.

The study also delves into the fact that costs in Los Angeles have increased more than 35% over the past five years. ***It is very interesting to note how this increase in costs runs parallel to the failure of the Utilization Review and Independent Medical Review systems which have been mandated in California.***

If an injured worker does not file a timely claim for Workers' Compensation due to pressure from his/her employer, supervisor or peers, it gives the employer an opportunity to raise a statute of limitations issue, which employers have been doing with greater frequency in the past 48 months. So, if a worker who knows or believes he/she has sustained a job-related injury does not timely file same because of feeling pressured not to do so, and residual problems eventually produce the need for medical care, time off from work, or permanent disability benefits, the employer — despite being responsible for the initial injury — will raise the stature of limitations issue to bar the worker (and his/her family) from receiving any benefits or recovery for the work-related injury.

It is incumbent upon the associations and their members not to be drawn into the misstatements which have been publicized regarding the Los Angeles Workers' Compensation claim audit relative to police officers and firefighters. These safety occupations naturally do have higher levels of injury, more injuries of a serious nature, and more injuries which require complex medical needs, than occupations which do not face life-and-death situations and the repeated risk of physical harm, such as a city council man or woman, an administrator of a program, someone who works at a computer, a gardener, or people in thousands of other occupations which function in what are routinely risk-free environments. That is not to say that those jobs cannot cause injury, but their physical and emotional demands are substantially smaller, and the need to file Workers' Compensation claims is considerably less, than is the case for police officers and firefighters.

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FIVE YEARS TO OBTAIN MORE JUSTICE; NO TIME LIMIT ON MEDICAL CARE

BY: SCOTT A. O'MARA

Two factors occurring with job-related injuries are the level of impairment and the need for medical care. The level of impairment is determined by medical opinions and comparing the objective findings (*i.e.*, test results) with the subjective complaints of the patient using a schedule which has been created to produce this measurement. Once the level of impairment has been determined, a worker has five years from the date of injury to have the impairment level re-evaluated.

Labor Code §5410 indicates that the level of impairment, once it has been legally determined, can be re-evaluated and potentially expanded because of the changes. The Labor Code states that the Workers' Compensation Appeals Board maintains jurisdiction within five years from the date of injury to determine if new and further disability has developed.

A so-called "settlement" can be reached as to the level of impairment, and the worker receives medical care. Even with care, some workers may experience a gradual degradation in activities of daily living and employment opportunities – *i.e.*, an increase in the level of disability. In the case of unrepresented injured workers, very rarely will they be advised by their employer of their right pursuant to Labor Code §5410 to reopen their case and increase their level of impairment.

A factor is injured workers' discussions with their treating doctor regarding their deterioration. When deterioration factors are present, the Labor Code allows workers the opportunity to go back and receive a "full cup of justice" as to their real level of impairment. However, to initiate this avenue of justice, a petition to reopen a case for new and further disability needs to be filed within the set time parameter of five years following the date of injury.

Along the same line, if an injured worker has an increase in disability within the five-year time period following the date of injury, there may be additional ancillary medical care which is needed to deal with a work-related injury. An example would be the following:

If a worker with a work-related heart condition develops non-work-related diabetes after the finding of the heart condition, and the doctor opines that the diabetes is impacting the heart condition and needs to be controlled to minimize the heart condition, the responsibility for providing medical care for the diabetes then falls upon the employer.

This expansion of medical care is *not* limited by five years. But if there is an expansion of medical care within five years, this may be one of the factors to examine as to whether the injured worker has an increase in his/her residual impairment.

An ancillary situation would be in the case of an injured worker with a work-related right knee injury who places more reliance upon his/her left knee to the extent that the left knee eventually becomes disabling. In such a case, the worker would then be entitled to medical care for the left knee also because of its relation to the right knee. Furthermore, if this occurs with five years of the original date of injury to the right knee, the worker would then be in a posture to examine the level of impairment related to both knees.

Another situation which occurs is that the worker has residual impairment related to a body part, say his right wrist, and the residual impairment is found to be 60% job-related and 40% non-work-related. Then, when the worker undergoes surgery, the disability increases – not because of the injury itself, but because of the surgery which did not go well – and the Court, based on case law, determines that the increased disability is because of the surgical process, then the level of impairment cannot be apportioned to non-work-related condition.

The Workers' Compensation system was designed to protect workers and their families, and an awareness regarding medical care and its expansiveness is paramount for the full protection of injured workers. Medical care for particular job-related injuries in more extreme cases can include such benefits as renovating a house, installing a ramp in the bathroom or to an entrance into the house, changing a stairway, having someone come to the house to provide medical care to the injured worker, etc. In the most extreme situations, depending upon the injured worker's medical condition and level of disability, 24-hour assistance may be provided for job-related injuries.

If you have a job-related condition, be aware of the time period to reopen your case for new and further disability. The expansion of medical care is not restricted to five years. And if in fact medical conditions evolve which are not work-related, but which impact a work-related injury, that still could be the economic responsibility of the employer.

As you review your case and consider the care you are receiving, this situation is fluid. Again within the five-year parameter, you can reopen your case to receive adequate compensation to reflect the residual impairment. More expansively, as set forth in Labor Code §4600, the medical care provided for work-related injuries is to "cure or relieve the injured worker from the effects of his or her injury" and this care "shall be provided by the employer".
In preparation for discussing your medical needs with your doctor, it is important to understand the foundation for reopening your case for new and further disability and/or for continuation and expansion of medical care.

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SPECIFIC INJURY, CUMULATIVE TRAUMA INJURY AND ANCILLARY INJURY

BY: SCOTT A. O'MARA

Workers' Compensation provides benefits to the worker that sustains a job related injury. The benefits can be medical care to cure or relieve the effects of the injury, compensation for time off of work, compensation for residual impairment that exists post maximum recovery period.

The common awareness is the two types of injuries that have to be proven as job related; a Specific and Cumulative Trauma injury. The more complex injury requiring additional development is the Ancillary Injuries.

The injuries that are occurring in the work situation require substantial documentation and the support of the treating doctor and/or the forensic doctor that is doing the evaluation.

This platform requires an expansion of understanding by the worker as to the various elements of the above-mentioned three types of injuries. This understanding must be factually correct and provided to the treating doctors and their staff so the substantial evidence platform is there that supports the injuries.

One of the major injuries that are not embraced by the employer is the Ancillary Injury. This injury expands the employer's liability to provide medical care to cure or relieve the effects of the injury. In addition it expands their liability for levels of permanent impairment they may emanate. For the worker, this understanding of all three types of injury and preparation provides a broader platform of protection for the worker and their family.

The physicians that are providing the medical care may be in an area of specialty and view the Ancillary body systems or Ancillary conditions subordinate to the medical care they are authorized to treat. Employers may not want to have to authorize other body systems and limit the treating doctor's medical care to ancillary problems. Examples of Ancillary Injury are where the medication, surgery or other forms of treatment of the job related condition causes harm and/or injury. Documentation of same is necessary. The worker must review all of his/her medications from https://www.webmd.com/ and look at side effects of medications they are taking. If these side effects are there, this must be identified to their treater. This is another important area that the worker's attorney needs to help develop (Medical Care Can Expand https://law1199.com/wp-content/uploads/2019/03/2019-issue-2.pdf.)

The preparation of the worker, by his/her attorney, prior to the treatment and forensic evaluation are paramount factors that can create this platform of protection.

The Ancillary Injury is reviewed as to whether the original injury is a contributory factor to the Ancillary Injury, and if so this provides an additional platform of medical care to cure or relieve the effects of the injury.

A common example is where the worker sustains a unilateral problem either in the leg or arm, and over use of the other extremity that was not injured occurs. If compensating increases problems to other body parts that were not originally injured this then becomes a compensable consequence of the first injury, an Ancillary Injury.

We see this common in leg injuries, such as an injury to the right leg and the worker relies more upon the left leg, back and upper extremities to move and get around. As a result of such, these additional body parts become symptomatic and develop the need for medical care or residual impairment, or both. In this situation there is a compensable consequence, Ancillary Injury and the employer under the workers' compensation system becomes responsible.

The Ancillary Injury is one where the employer wants to limit themselves from. The physicians that are providing the care many times are there for the role to provide care, but not looking to the legal consequences of the Ancillary Injury.

Another area besides the payment for disability to the injured worker that occurs can be the medical care. Medical care is to cure or relieve the effects of the injury and if the medical care causes further medical issues again, this is an Ancillary Injury.

This is an area where the employer and some medical providers are not going to jump forward to provide that coverage. The medical provider should acknowledge that there is a problem, but not necessarily come back and state it as a compensable consequence. The employer is not going to vet this out because it again creates a larger field of liability.

Unfortunately in many situations with industrial injury, particularly orthopedic injuries, there can be a significant weight gain. With the occurrence of weight gain, this can impact the heart system, pulmonary system and other body parts. The job injury can also make preexisting non work related medical conditions more problematic, such as diabetes. Even if there is a preexisting condition that existed prior to the job related injury if the condition becomes more problematic or more symptomatic because of the current job related injury, this becomes another factor in the compensable consequences of the injury. This is also an Ancillary Injury.

The workers awareness and discussion with the doctor is the foundation of evidence. The attorney that is representing the injured worker will be able to determine the potential for the Ancillary Injury and can help the worker focus on the proper communication with the medical providers to document same.

The workers' compensation system is one for protection of the worker. The workers' compensation system can raise the cost and liability to the employer. There can be employer views in conflict with the worker wanting to protect and secure medical care to cure and relieve the effects of the injury with the employer wanting to limit or eliminate costs. Knowledge is the key factor for the worker, and by the information garnered from the counsel, (the attorney for the worker), the worker is in a better position to protect themselves and their family for costs of medical care.

The employer is liable for any resulting disability or need for medical treatment arising from the job related injury or compensable consequence of same. One of the more telling cases that speaks to this is one litigated by this office, the *South Coast Framing, Inc. v Workers' Compensation Appeals Bd (Clark) (2015) 61 Cal.4th 291 [188 Cal. Rptr. 3d 46, 349 P.3d 141, 80 Cal.Comp.Cases 489*]. This was litigated by Daniel J. Palasciano of O'Mara & Hampton; a very significant case in workers' compensation that helps set forth the definition of a job related injury.

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YOU ARE ENTITLED TO PRIVACY

BY: SCOTT A. O'MARA

The California Constitution, Article 1, §1; the Health Insurance Portability & Accountability Act (HIPAA); the Confidentiality of Medical Information Act (CMIA); and Labor Code §3762 are all legal enactments which afford California injured workers several layers of privacy resulting from legislative actions and Supreme Court decisions.

The first statement of privacy rights is set forth in the California Constitution, Article 1, §1, which states:

"All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy."

The California Supreme Court, in *Hill v. National Collegiate Athletic Assoc. (Hill)* (1994) 7 Cal. 4th 1, reinforces the right to privacy and sets forth a cause of action which an individual can civilly pursue for invasion of privacy under the U.S. Constitution. This case speaks to medical information, the reasonable expectancy of privacy, and the serious nature of invasion of privacy, whether its impact on the individual is actual or potential.

In the Workers' Compensation arena — whether a case involves an insurance carrier or a third-party administrator — there is no justification for an ***employer or employer's agent*** to have access to a worker's medical information, or to speak to the worker or his/her doctor regarding the particulars of their medical information when California law provides for the employer to obtain the information needed regarding the employability of the injured worker from the claims administrator. The law effectively creates a wall between the claims administrator and the employer concerning the disclosure of medical information.

The third-party administrator — whether it is State Compensation Insurance Fund or another entity, or an in-house administrator such as Risk Management or the Department of Human Resources — is limited to disclosing information within their possession, which balances the employer's need for information with the worker's right to privacy. The employer, through their agent for the administration of Workers' Compensation claims, can acquire *basic and limited* information regarding the employability of the worker.

The Labor Code, the California Constitution and case law all reflect a strong and narrow limitation as to an employer's access to information. Labor Code §3762 states as follows:

(c) An insurer, third-party administrator retained by a self-insured employer pursuant to section 3702.1 to administer an employer's workers' compensation claims, and those employees and agents specified by a self-insured employer to administer the employer's workers' compensation claims, are prohibited from disclosing or causing to be disclosed to an employer, any medical information, as defined in subdivision (b) of Section 56.05 of the Civil Code, about an employee who has filed a workers' compensation claim, except as follows:

(1) Medical information limited to the diagnosis of the mental or physical condition for which workers' compensation is claimed and the treatment provided for this condition.

(2) Medical information regarding the injury for which workers' compensation is claimed that is necessary for the employer to have in order for the employer to modify the employee's work duties.

Civil Code §56.05 also articulates relevant ideas as to what medical information employers need and provides guidance as to where they should not go.

The Confidentiality of Medical Information Act (CMIA) reinforces limitations on employer access to medical information. Labor Code §3762 specifically limits what information the administrator of Workers' Compensation claims may disclose to the employer. Most importantly, Workers' Compensation laws provide the method by which employers may obtain — ***from the claims administrator, not the treating doctor*** — the limited information necessary to determine an injured worker's employability. Additional liability may be placed upon physicians who engage in violation of CMIA, as set forth in the case of *Pettus v. Cole* (1996) 49 Cal. App. 4th 402.

Therefore, employers are limited in their access to medical information, and treating doctors are limited in what they are allowed to disclose.

As citizens of the great state of California, we are afforded several levels of privacy. As established, these privacy rights emanate from the Supreme Court's decisions and its interpretation of the California Constitution's Declaration of Rights and numerous legislative enactments. Case law has narrowed the scope of medical information discoverable in Workers' Compensation cases.

Therefore, if your employer seeks to have you sign a medical release form on an orthopedic case — and the form indicates you are approving access to information relative to marital or drug counseling, drug usage, psychiatric or psychological care — be aware that such form would not be an appropriate discovery vehicle for the employer, as it is too broad and violates privacies afforded California workers under the California Constitution and the case law interpreting same.

If your employer wants to meet with you to inquire as to your diagnoses, the treatment you are receiving, and the restrictions the doctor has placed, be aware that these inquiries are not appropriate, and this information must be provided to them through the Workers' Compensation carrier, a third-party administrator such as SCIF, or an in-house claims administrator such as Risk Management or the Department of Human Resources.

From time to time, situations arise where the supervisor — whether it be a sergeant, lieutenant, captain, battalion chief, division chief or higher-ranking officer — will seek information regarding a worker's medical condition and force the worker to meet with the supervisor to provide information regarding such subjects as the treatment being received and the restrictions which have been placed. Such action by the employer is inappropriate. If it occurs, you can state that your counsel has instructed you not to address these issues (unless you receive a direct order to do so from command, in which case you will follow same). However, persisting with such questioning will create a point of individual liability for the person in command.

The concept of privacy is pertinent and appropriate and is embraced by the California Constitution, the Civil Code, and the California Labor Code, which sets forth a prohibition from disclosing or causing to disclose to the employer medical information which is limited by Labor Code §3762. If you have questions, please do not hesitate to contact us.

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MEDICAL CARE FOR PREEXISTING CONDITIONS

BY: SCOTT A. O'MARA

If the worker has a job related injury there is entitlement to several benefits; one of the most important benefits is medical care. The California Constitution states that medical care for job injuries is to CURE or RELIEVE the effects of the job related injury.

The employer wants to contain and control as many costs as they can in the work related injury. In doing so, they then attempt to remove any medical condition that has become more disabling or problematic because of the job related injury.

The labor code speaks very generally that an injury is the result of a specific or cumulative trauma of work events or disease arising out of the employment. However, there are many situations where there is an aggravation of preexisting medical conditions that were non-industrial and this preexisting medical condition, whether that be a disease or condition, has connectivity because the work related injury, or the treatment for the work related injury, aggravates or accelerates those preexisting conditions. This then makes those conditional changes in the body or the system compensable, particularly when it comes to the medical care.

The employer does not want to see this expansion of medical care because the medical care can be a lifelong obligation for the employer that was not initially impacted by the specific or cumulative trauma, but the condition became more problematic or more symptomatic as time passed because of the aggravation of this preexisting condition(s).

One of the thoughts is that a compensable consequence would be that the worker sustained an injury to his left knee and then becomes more reliant on the right knee to move around. Due to this, the right knee becomes more symptomatic and needs medical care; this would expand the coverage under the workers' compensation system. Another example would be a worker that has a non-industrial heart condition existing prior to his employment of the

job related injury. With the job related injury, if it has caused an elevation in the blood pressure, and this elevation of the blood pressure has caused an enlargement of the heart, this then would place the responsibility for the medical care for the heart to the employer.

The case law is rather direct that if the industrial injury or treatment for the industrial injury aggravates or accelerates the previous existing disease or condition resulting in disability, the injury is compensable for a level of disability and becomes the responsibility for the employer to provide the medical care for this new element.

Of interest is the elements of change, most workers do not have knowledge of, nor do the physicians that are treating, understand or embrace the concept of the aggravation of the preexisting non-industrial condition. The job related injury is the responsibility of the employer. The doctors that treat under the employer's medical provider network list are doctors that are limited in their full medical view and as are the doctors in the Carve-Out. If these doctors expand medical care under the workers' compensation system, the doctor will be under review by the employer or adjuster for additional costs. This awareness the doctors have can remove the unrepresented worker from the full medical protection for them and their family because of the aggravation of preexisting non-industrial disease or conditions by the job related injury or treatment.

There can be changes in medical conditions that are non work related. These changes are initially considered to be non work related by either the work related injury or the medical care received for the work related injury. These changes must be reviewed and embraced as a responsibility of the employer. The treating doctors are a very important element to articulate how the above mentioned injury or medical care for said job related injury are a factor in the aggravation or worsening of the preexisting non industrial disease. The medical care is articulated by the California Constitution is the Cure or Relieve the effects of the injury and the broad perspective is necessary for full protection of a California injured worker.

Therefore, it is paramount that there is a continuous review as to any worsening of preexisting or new medical conditions that developed in part or in total because of the job related injury, or for care for the job related injury causing same.

The role of the treating doctor is a significant factor for access to medical care. In addition, there must be awareness that the employer's doctors that are on their medical provider

network list or doctors on the Carve Out list may view the cases very narrowly to continue to have their standing as treaters for the employer.

The injured worker through their attorney must expand the knowledge and the responsibility of the treaters so the medical care is available to Cure or Relieve all medical conditions, either current, preexisting or in the future, that are related to the job related injury and that the job related injury or treatment for same has impacted either preexisting need for medical care prior to the injury, or additional medical care that develops after the job related injury.

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MEDICAL CARE CAN EXPAND

BY: SCOTT A. O'MARA

The worker that has a job related injury can be entitled to receive medical care to cure or relieve the effects of the injury. Typically, the medical care is ascribed to a particular system and/or body part that were injured in the job-related event, and the medical care can be expanded.

There can also be supplemental medical care that is connected to a particular body part and/or systems that were not specifically injured in the job-related event. The connectivity is that the non-related body part or system is that it must be treated to alleviate or minimize the body parts or systems that were injured in the job-related event such as a job-related heart condition but the worker has non-related diabetes and the diabetes is negatively impacting the heart. Therefore, the Workers' Compensation system will have to provide treatment for the diabetes (expanded care).

The courts have determined there are situations where the injured worker who receives medical care for the industrial injury and this medical care causes ancillary problems not directly related to the job-related injuries create responsibilities for the employer. These ancillary problems requiring medical care and treatment, again, can be the responsibility of the Workers' Compensation provider. If it is determined that the care received for the work-related events has a deleterious effect causing the change in function or dysfunction for the worker, again, the responsibility for care lies with the Workers' Compensation provider (expanded care).

Some of the areas that can be easily defined would be the side-effects attributed to the prescribed medication. The side-effects can be as simple such as dryness of the mouth, sensitivity to heat, swelling of extremities, gastrointestinal problems, diarrhea, constipation, blood in the stool, etc., all fall within parameters of the Workers' Compensation system. The worker can use https://www.WebMD.com to review listed side-effects for their

medication, and, if they determine that those side-effects are there and they do indeed emanate from the medication, this, again, becomes the responsibility of the employer.

Key factors in the Workers' Compensation system and the employers' liability is a potential of connectivity to inadvertent harm that occur in the treating of a job-related injury. If the physician is not using the proper knowledge, judgment, or skills required and this treatment causes a worker the harm the need for care and treatment associated with that is responsibility of the employer under the Workers' Compensation system (expanded care).

The medical industry has many people that are participants, some have a strong economic goal of achievement for themselves and they are not readily willing to acknowledge or advise the parties associated risks and/or consequences with the treatment offered.

One of the areas that are coming under review is the opioid medication. There is a company that produces the opioids and charges have been laid and fines imposed regarding the misusage of this medication. For the patient that has side-effects, whether it is an addictive quality of the medication or other aspects, those injuries or harm caused falls with the providers of Workers' Compensation.

In the medication realm, some of the pharmaceutical companies are aware of the harm caused by the particular medication, and, they are designing new pharmaceutical products to deal with the side-effects of the medications – *two sources of revenue for them.*

There have been numerous discussions in lawsuits filed against a provider that they were concealing information that caused harm and damage to the patient.

The side-effects of medication whether it is an addictive component, kidney failure, sensitivity to skin, or complex situations evolve are a continuation of the responsibilities of Workers' Compensation. The workers may also have additional causative actions, against the doctor and/or the provider depending upon the injury and/or the knowledge that the provider had and did not disseminate for the worker to make a determination, or a cause of action against the drug manufacturer.

Another realm that is considered is a pre-existing condition such as being overweight. For example the worker develops job-related back conditions and weight issues. Even though the weight condition is not job-related, if the weight condition exacerbates or makes recovery more difficult -- Workers' Compensation can be mandated to provide a weight reduction program if it improves the ability for the job-related injury to get better. Therefore, if the weight condition exacerbates or makes the recovery more difficult -- Workers' Compensation can be mandated to provide a weight reduction program

improving the workers ability to get better regarding the job-related injuries, and the medical care can be expanded (expanded care).

The complexities of the job-related injuries and the treatment regarding same require significant understanding by the worker. Again, the side-effects of the treatment can be complex but the key for the worker and usage of the system is the recognition that medical care to cures and relieves the effects of the injury is not just limited to just the body part that was the job-related injury, and the medical care can be expanded.

The workers awareness of the side effect of the treatment the awareness, of changes that may be required to his/her existing body system through treatment, open up another source of proper treatment under the Workers' Compensation system. Finally, the improper care such as opioid situation or malpractice by the doctor remains a primary responsibility of the Workers' Compensation system yet allowing the worker a separate cause of action for medical malpractice or improper development and marketing of the medications.

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LEGISLATIVE HISTORY OF THE PRESUMPTIONS FOR SAFETY EMPLOYEES AND THE IMPORTANCE OF BEING AWARE AND BEING PROACTIVE

BY: SCOTT A. O'MARA

In the mid-1930s, California legislators recognized that safety employees face a unique risk of harm through their work as peace officers. This recognition has been reflected in past and current legislative changes establishing various presumptions of work-related injury for safety members.

This legislation initially was for hernias, but was extended to include heart trouble in 1939 and tuberculosis in 1957. Many other changes have occurred since then, and in 1975 coverage were correctly expanded to include injuries manifesting within five years of the last day a safety member actually worked. Further expansion occurred in 1976.

In October 1997, as a result of the Dan Stanley case — which was litigated by this office — hernia coverage was expanded to include not just inguinal hernias, but other types of hernias as well, such as protrusions in the bowel region.

In 2003, the Walter Faust case — again litigated by this office — provided direction and clarity as to the cancer presumption, shifting the burden of proof to employers. Prior to this successful litigation, the cancer presumption had minimal value.

In 2010, Labor Code §3212.1 was amended to extend application of the cancer presumption following termination of service up to 120 months, depending upon the length of service.

On 5/13/14, Gov. Brown signed Assembly Bill 1035, which expanded the eligible period for family members of specified deceased safety members to receive death benefits related to certain illnesses from 240 weeks after the date of injury to a possible maximum of 420 weeks after the date of injury.

However, despite these time limits for accessing benefits under the presumptions — 120 months maximum for cancer, and 60 months for other presumptive conditions — there is case law which correctly establishes that the 60/120-month limit depends upon the particular facts of each case.

There is also recognition that various diseases have different periods of latency in their manifestation. Therefore, in some situations, the 60/120-month statute limiting access to benefits does not have application, dependent upon the documentation of the patient's subjective complaints to the doctor consistent with the development of the disease process.

For instance, if a worker has cancer which finally is diagnosed more than 120 months after his/her last day of work, but the worker previously had reflected pain or bladder/ bowel problems to the doctor, or reported subjective complaints consistent with a long-developing disease process, the 60 or 120-month limit does not apply, and the injured worker still can receive Workers' Compensation benefits pursuant to the cancer presumption.

Therefore, it is imperative for workers and their families seeking benefits to recognize the 60 and 120-month windows for reporting injuries, and the 420-week window for accessing death benefits.

Under Workers' Compensation, the medical care for job-related injuries is very extensive and expansive. It covers not only any treatment provided directly for the original injuries, but also any treatment for ancillary conditions which ultimately result from either the original injuries *or* the treatment provided for those injuries, including side effects from any medications prescribed for same.

In addition to medications, "treatment" can cover a wide variety of options, such as injections, surgery, hospitalization and nursing care (and in some cases acupuncture and chiropractic care), as well as surgical supplies such as crutches, orthotics and prosthetic devices. In extreme cases, medical care can also cover transplants involving organs such as the liver and the heart, and house reconfiguration if a job-related injury requires modifications to enable an injured worker to perform basic activities of daily living.

Furthermore, medical benefits under Workers' Compensation have no cap, unlike many health plans which have a cap of $3-to-$4 million per body system. One extreme example involves a client I represented many years ago. He initially underwent surgery for a work-related knee injury, but, as a very unfortunate consequence of that surgery, he

developed phlebitis, which led to a stroke. As a result of the stroke, he developed a life-long need for home health care — including home modifications. *All these extreme medical needs have been and continue to be covered entirely by Workers' Compensation because they stem from treatment for the client's original injury, which was job-related.* The cost for this care initially was $60,000 per year, and it now has risen to more than double that amount.

Therefore, by establishing that an injury is job-related, a worker can gain access to expansive medical care without a cap.

Recently, I completed a case where the injured safety member was 15 years beyond his last date of employment. Despite that fact, I was able to establish his eligibility for the presumption that his injury condition was work-related. The success of this case had a tremendously positive impact on the worker and his family. The medical and home health care provided went well beyond the parameters or what Blue Cross, Kaiser or other health plans could have provided.

All safety members who are retired or approaching retirement must be candid as to their medical condition. Unfortunately, many members spend many years denying that they have a serious medical condition, or that their condition has any connectivity to their work. These types of denials can potentially have severe economic consequences for themselves and their families.

Therefore, as you examine your health and any medical condition which may be evolving, you need to face the truth of that condition, and be aware of its possible relation to your safety career.

Also, if you have an accepted condition which is job-related, and you take medication for that condition, and that medication causes an ancillary condition, remember that the ancillary problem becomes the responsibility of Workers' Compensation. Therefore, you should go to WebMD to research the side-effects of all the prescribed medications you take for your work injuries. *Do any of the side-effects listed for your medications match symptoms you are experiencing?* If so, and if any of the symptoms first appeared or worsened after commencing the medication(s) in question, those symptoms then become the responsibility of Workers' Compensation.

Also be aware that some medication for heart conditions can cause kidney problems or kidney failure. Therefore, any safety members who have heart conditions should be aware of this potential development, and seek care under Workers' Compensation for any such kidney problems.

In conclusion, to protect yourself and your family, it is very important to be aware of the information discussed above, and to be proactive when it comes to recognizing your health problems and seeking treatment under Workers' Compensation for any conditions which may be work-related.

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BALANCED COMMUNICATION WITH THE DOCTOR

BY: SCOTT A. O'MARA

California's Workers' Compensation laws were enacted by the legislative body to ensure fair and just treatment for California workers who incur injuries in the course of their employment. This legislation has been enacted to provide workers with the medical care they need to cure or relieve the effects of their work injuries through their entire lifespan. The specific language guaranteeing workers access to this right is set forth in the California Constitution, Article XIV, Section 4, which specifically states:

> [A] complete system of workers' compensation includes . . . full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injury . . ..

The determination as to the need for care to cure or relieve is based upon several factors. One is the doctor's opinions and findings regarding the job-related injury. The physician's evaluation will be based upon his or her examination of the patient, as well as statements made by the patient as to pain and discomfort and/or restrictions they believe they have — which are referred to as subjective complaints.

In addition, the evaluating doctor will use objective findings — based upon an x-ray, MRI, EKG or other objective testing, such as the configuration of blood drawn from the patient, or elements found within a urine sample.

The injured worker's description of subjective complaints is a significant element in the determination as to the type, necessity and length of care which may be needed. These complaints can have substantial importance in the doctor's determinations regarding these factors . . . as well as the credibility of the worker.

Injured workers must realize that these are not cavalier statements. They are statements which can impact their care and their access to same — potentially throughout their lifetime.

Prior to meeting with a physician, an injured worker should give some thought and preparation as to their subjective complaints to make sure the characterization they give provides a broad spectrum as to what they are experiencing relative to any restrictions, limitations, discomfort, etc. (*Law 1199 – 2019 #4 / Law 1199 – 2019 #8*)

Regarding subjective complaints (other than extreme medical problems), injured workers may have times when they have good days and bad days. Articulating this fact — if it is accurate — will support the credibility of the worker, as opposed to the worker who only wants to articulate their pain and discomfort without acknowledging that they may have times when they are doing better.

Prior to being evaluated by the doctor, an injured worker, if given the opportunity to speak with his or her attorney, can share their perspective regarding pain and discomfort. If the attorney is educated and balanced, they will ensure that the worker's articulation will provide a broader view of what is being experienced, as opposed to a narrow view of only the days which are totally disabling because of pain and discomfort.

Many eyes will always evaluate the concept of subjective complaints, which will be considered not only by an injured worker's primary doctor, but also any secondary doctors who may be called in to review an ancillary problem, as well as any nurse case managers and adjusters. Therefore, a worker's subjective complaints can prove to be paramount as to their perceived credibility, as well as their access to — or denial of — medical care.

Substantial evidence is the determining factor which allows or denies the ability of an injured worker to receive appropriate medical care. The substantial evidence is based upon full and complete reflection of a worker's injuries to his/her doctor. Substantial evidence can either make or break a case, and is the standard established by the courts. (*Law 1199 – 2019 #4 / Law 1199 - 2019 #8*)

Medical care provided to injured workers is intended to cure or relieve the effects of their work injuries. It can be expanded, and some of the expansion may result from the form of treatment. If the worker takes medication for a job-related injury, and that medication cause an ancillary problem — such as dryness of the mouth, diarrhea, constipation, gastrointestinal problems, etc. — the ancillary problem (or problems) become the responsibility of the Workers' Compensation system.

Injured workers would be wise to keep a list of the medications they are taking — including both those prescribed by their doctor or other doctors, and over-the-counter medications, such as Tylenol or aspirin — and go to WebMd to research the side-effects of those medications. The question is always this: *Do any of the side-effects listed for your medications match symptoms you are experiencing?* Please be aware that any symptoms or problems caused by medication taken for a job-related injury can also be deemed to be work-related — and therefore become the responsibility of Workers' Compensation — if the symptom or problem first appeared or worsened after the medication was commenced. Therefore, if you discover after researching this matter that any of the listed side-effects of your medications *do* match symptoms you are experiencing, please inform the doctor of same so this information is documented, and also

inform your attorney to ensure that they have filed on all the body parts and medical conditions relevant to your case.

Medical care also has an expansive element. For example, if an injured worker is diabetic and has a work-related heart condition, and the doctor opines that the diabetes is negatively impacting the heart, medical coverage extends not only to the heart, but to the diabetes as well.
Also, medical care can develop to the point where it includes not only medication, testing and surgery; it also can include such other aspects as renovation of an injured worker's living area and assistance with transportation. There are situations where the job-related injury has been a factor in causing a stroke which mandates 24-hour care and renovation of the worker's home. In that situation, medical care is expanded accordingly to meet the worker's needs.

Ancillary to the medical care needed to cure or relieve the effects of a work injury is the interpretation as to the worker's level of impairment — and this level can be expanded. As established by law, once an award has been granted by the court establishing a level of disability, the worker has five years from the date of injury to reopen their case for new and further disability if the effects of the injury have expanded. The five year window applies only to permanent disability; it does not impact access to medical care, nor does it limit such access. These elements in the Workers' Compensation system, medical care and level of impairment, are significant factors which require an understanding and knowledge on behalf of the injured worker. If an injured worker does not have access to these perspectives, there is a high probability that limitations will be placed upon them. (*Law1199 – 2019 #1*)

The reflection of subjective complaints is a very significant component in the provision of medical care and the level of impairment. If an injured worker's subjective complaints are not given broad consideration, it creates a unique opportunity for the employer to question the worker's credibility. In fact, the question of a worker's credibility is part of the training and focus which adjusters have as they look for ways to remove or limit the care which is provided to an injured worker, as well as the level of disability.

We have seen the evolution of the Workers' Compensation system to include medical provider network (MPN) lists, as well as Utilization Review and Independent Medical Review — the development of which has been beneficial to employers, and detrimental to workers.

A new step which also is being pushed is the concept of a "carve-out (ADR -- Alternate Dispute Resolution)". If done improperly, a "carve-out (ADR -- Alternate Dispute Resolution)" creates great risk of harm to injured workers. (*Law1199 – 2019 #4* and *#8*)

Again, it is a necessity for workers to have an understanding that the information which will be sought from them should not be limited just to their bad days, but should articulate that they have both good days and bad days — a concept which reinforces their credibility. This is something that injured workers involved in a "carve-out (ADR -- Alternate Dispute Resolution)" may not grasp or understand because the foundation of evidence in a case is delayed without an attorney's involvement. If an attorney is involved at the initial stage of a case, the attorney can share his/her concerns and thoughts, which then can be placed in an environment which is objective and addresses not just bad days, but both good and bad days, thereby creating a high level of veracity

for the worker. Balanced Communication is an absolute need. Your attorney will help to develop that communication.

If an injured worker does not have the opportunity to discuss this matter with his or her attorney, there is a high probability that the subjective complaints will be overstated or possibly understated. If an injured worker does not acknowledge problems which are evolving, this can remove needed care.

An example would be a worker who has a very serious injury to the right leg, causing this individual to rely more and more on the left leg, and they develop problems with their upper extremities when going up and down stairs. The condition of the upper extremities can be considered a compensable consequence of the right leg injury, and the worker would therefore be eligible to receive care for the upper extremities as well. If the worker does not understand the connectivity of the injury, the treatment and the medication, it limits the care which could be received, and limits the doctor's complete understanding of the situation. However, if the worker appreciates the connectivity of these factors, it expands the care which he/she can receive.

For job-related injuries, medical care is a significant factor in leading to a good quality of life. The relationship and the balanced communication the patient has with their physician is one which can provide a clearer picture as to both their current needs and their future needs. Be prepared to not overstate or understate your subjective pain or the activities you can or cannot do, or your limitations. *COMMUNICATION MUST BE BALANCED.*

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RETIRED OR CONSIDERING RETIREMENT? THEN DON'T FORGET TO CONSIDER THIS!

BY: SCOTT A. O'MARA

All safety members who are retired or are considering *retirement* should have a good understanding of the following three factors: their medical care; the importance of the Workers' Compensation presumptions as they apply to work-related injuries; and the value of maintaining sufficient insurance coverage to ensure adequate protection for themselves and their families in the event of a vehicular accident. A lack of knowledge in these areas can severely impact the quality of life for a safety member and his/her family and result in dire economic consequences.

MEDICAL CARE

The medical care that can be obtained under the Workers' Compensation system, albeit not as all-encompassing as it once was, still provides a means whereby both current and retired safety members can maintain financial solvency if their medical condition has connectivity to their work. The medical care available can actually be expansive when a work-related injury is involved.

Take, for example, the case of a worker who has a job-related cardiovascular problem which is made worse, or could be made worse, by another medical condition that is not work-related. If an individual with a cardiovascular problem becomes diabetic, the only way to adequately and properly control the cardiovascular condition is to control the diabetes. As a result, the diabetes then falls within the parameters of Workers' Compensation.

Another example would be a worker who takes medication for a job-related condition, but that medication creates another medical problem. For example, medications can create esophageal reflux, gastrointestinal problems or erectile dysfunction. My advice is to go to a website such as WebMD and, one by one, place the name of each medication taken in the search box to learn the side-effects of these medications. If in fact the member has an additional medical problem caused by medication taken for a job-related injury, the ancillary medical problem then becomes the responsibility of Workers' Compensation as well.

A more extreme example would be a worker who develops paralysis (*i.e.*, experiences a stroke) as a result of a job-related condition, and the paralysis requires 24-hour home health care. Because

of the connectivity between the paralysis and the work-related injury or illness, Workers' Compensation will cover the home health care.

While some health policies place a cap of $3-or-$4 million per body system or part, Workers' Compensation does not have this limitation. Therefore, if a connection exists between a job-related injury or illness and the care required for a serious medical condition, one can easily see the advantage of establishing that connectivity.

MEDICAL PROVIDER NETWORKS

However, even with the expansive nature of Workers' Compensation coverage, the injured worker needs to be aware of how to deal with providers under the Medical Provider Network ("MPN"). MPN doctors need to be reminded that they are physicians and have an ethical and moral responsibility to the injured worker. They should not be simply an extension of the insurance carrier adjuster and what the adjuster wants in the Workers' Compensation case.

When necessary, an injured worker can access the Medical Quality Control Board, which is the licensing board for physicians. This option can be of value in certain situations in redirecting a doctor's or medical group's priorities to ensure the provision of adequate medical care for the worker.

THE PRESUMPTIONS

As some safety members are aware, California, through special legislation, has created a number of work-related presumptions. That is, if certain medical conditions evolve or develop, they are *presumed* to be job-related. These conditions include heart trouble, hernias, pneumonia, cancer, tuberculosis, blood-borne infectious disease, injury or illness resulting from exposure to biochemical substances, meningitis and lower back injuries. *(The presumption for lower back injuries applies only to specified peace officers — not all safety members.)*

While all the above conditions may be *presumed* to be job-related, it should be noted that these presumptions are *rebuttable*. That means that if an employer can demonstrate the proper fact pattern, the presumption that an injury or illness is job-related may no longer apply, and medical care under Workers' Compensation may be denied.

TIME PARAMETERS*

**Non-Cancer Cases: 60 months; Cancer Cases: 120 months.*

Also, upon the first reading of the statutes establishing these presumptions, they appear to be limited by time parameters based upon the length of employment of the safety member and the date when he/she ceases that employment. According to the Labor Code:

The presumption shall be extended to a member following termination of a service for a period of three calendar months for each full year of requisite service, but not to exceed 60/120 months* in any circumstance, commencing with the last date actually worked in the specified capacity.

In the vast majority of cases, as most safety members are aware, the development of various medical conditions does not occur with one particular exposure, but with sustained exposures throughout the period of employment. Also, the latency period between the exposures and the actual manifestation of a particular illness may well be beyond the 60/120-month* limit. That has led to the misconception that because the manifestation of the illness – or the death of the safety worker from that illness — occurs outside the 60/120-month* window, the safety worker or his/her family may be denied a full cup of justice. *However, that is not necessarily true.* Each individual case must be reviewed on its own merits, with emphasis on exposures and manifestations.

For example, we recently completed a safety member's death benefits case where the death actually occurred well outside the 60/120-month* window. However, based upon the facts presented, which were consistent with particular case law, the court ruled that the widow was still eligible for the death benefit of $250,000.

THE VALUE OF LEGAL COUNSEL

An interesting note also about this case (and many others) is that had the widow not sought legal counsel and merely followed the employer's recommendation, she would have received a death benefit settlement of only $125,000. However, because of concerns raised by a fellow worker, this family came to our office, and their case was settled not for the $125,000 inappropriately offered by the employer, but for $250,000, as noted above. That means the family received an additional $125,000 of much-needed money as a result of taking the initiative to obtain legal counsel. Although death benefits are on the rise, the increase has not occurred fast enough to accommodate the tremendous needs of most injured workers' families.

While death benefits are a very important aspect of work-related injury/illness presumption, perhaps more relevant to most safety members is the provision of medical care for presumptive injuries. Again, by proper development of the record, the safety member, once his/her condition is shown to be job-related, is able to receive medical care under the California Workers' Compensation system for the presumptive body parts.

Obtaining medical care may require overcoming some hurdles, but the resulting benefit can be expansive. For example, care can include 24-hour in-home care for the member. Also, care can be extended to other systems that impact the job-related body part(s). For example, if a safety member has a heart condition and also is or becomes diabetic and the only way to control the heart condition is to control the diabetes, the diabetes then falls within the scope of Workers' Compensation.

As you may have read in many articles, Workers' Compensation benefits other than death benefits have been minimized in the last several years. The creative counsel will look for other ancillary medical problems that emanate from your job-related medical condition or the medications you take for it, whether those problems are in the realm of pulmonary, renal, continence, potency or other conditions. Counsel will then ensure that you have medical coverage, not just for the job-related condition, but also for any condition caused or made worse by the job-related injury or illness or the medication you take for it.

THE ADVERSARIAL POSITION OF THE EMPLOYER

I would strongly warn the worker and his/her family to realize that the employer is in an adversarial position when it comes to Workers' Compensation benefits. Their role is to minimize, *mitigate or deny benefits*, no matter how long you have been employed or what your political connectivity is to the employer. Therefore, regardless of the position you hold with your employer, and regardless of the social interaction you may have with Human Resources, the Board of Supervisors, the City Council or the Mayor, it is important to recognize that their role is different when it comes to providing full coverage under Workers' Compensation.

Your goal as the worker or family member is to ensure that you receive coverage and/or monies because of a job-related condition, and the only way this can be achieved is by building a proper foundation of factual material supporting the reality of the exposures, and establishing that the latency and manifestation period for a particular condition are supported by current case law which allows for the extension of benefits and coverage beyond the 60/120-month* limit defined in the Labor Code.

If you unfortunately develop a medical condition which potentially is connected to your work — and you are not within the 60/120-month* limit set forth by the Labor Code — *it is important that you seek counsel so the foundation on which your case ultimately will be determined is full and complete*. If you seek medical opinions without having the proper legal knowledge, the doctors you select, as well as the doctors to whom you are sent, while sharing social niceties with you, may not be placed in the best position to help you if you do not have or understand the proper history of exposures and symptomatology to share with them. *The result?* You and/or your family members may not receive your full cup of justice — *i.e.*, the medical care and money you rightfully deserve under the Workers' Compensation system.

THIRD-PARTY LAWSUITS

Besides Workers' Compensation and retirement, our law practice also involves third-party lawsuit cases when an allegation is made against someone other than the injured worker's employer or co-workers. Such lawsuits are based upon negligent conduct by a third party who causes injury to the person making the allegation. When successful, third-party lawsuits involve damages which include compensation for medical expenses, wage loss, and pain and suffering.

A significant difference between a third-party case and a Workers' Compensation case is the potential for unlimited recovery in third-party lawsuits versus limited recovery in Workers' Compensation cases. The first obstacle in a third-party lawsuit, however, is ensuing that sufficient insurance money is available to cover the responsible third-party's wrongful act and pay adequate compensation to the injured party.

UNINSURED/UNDERINSURED MOTORIST COVERAGE

Many times, unfortunately, third-party negligence is perpetrated by uninsured or underinsured motorists. However, you can protect yourself and your family against such negligence through the

purchase of uninsured/underinsured motorist coverage. This coverage is relatively inexpensive and provides financial security and protection in the event of an accident involving a negligent third party who is uninsured or underinsured. This coverage will protect your household members and yourself up to the limits of your coverage, and it applies whether you are the driver in the car involved or just a passenger, or a pedestrian who has been struck by the negligent driver.

This insurance typically is purchased through your auto insurance and usually mirrors your liability limits. However, you can purchase it through your homeowner's insurance or an excess/umbrella policy which has an auto uninsured/underinsured motorist endorsement.

The most recent policy I have seen provided $1 million uninsured/underinsured motorist coverage for a cost of approximately $300. Please note that this coverage is not marketed by carriers, but they are forced to provide it. Also, brokers many times do not have a full understanding regarding this type of coverage, yet its importance cannot be overstated. If your broker does not have such knowledge and understanding, please feel free to contact us directly and we can assist you in obtaining the coverage you need.

You, as a retiree or a potential retiree, have an opportunity to be proactive in your medical care. You also can be proactive in ensuring that any medical conditions which develop that may fall within the presumptions indeed are considered accordingly. Finally, you can protect yourself and your family against uninsured/underinsured motorists by communicating with your broker regarding obtaining the proper coverage.

Scott O'Mara is an attorney who has represented safety members for many years. A strong advocate of injured workers, he has served as Adjunct Law Professor at Thomas Jefferson School of Law and Assistant Professor at San Diego City College. Mr. O'Mara also has previously been appointed judge pro tem. He can be reached at 1-800-LAW-1199 or 619-583-1199; website: www.law1199.com.

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A DELAY OR DENIAL CAN CREATE A PENALTY

BY: SCOTT A. O'MARA

The Workers' Compensation System has been misused by some employers/agents by treating the injured worker unfairly or badly in the delay or denial of treatment, or payments of lost wages. This can violate the California Constitution, which mandates under Article 14, Section 4, that there is to be a complete system of workers' compensation. A part of that system is to cure or relieve the effects of the injury and compensate the worker for any disability that emanates from the work injury.

In addition to this mandate by the California Constitution, it became recognized that there is a large segment of certain exposures which are unique to various occupations such as peace officers and firefighters, where the work-related exposures can create very serious medical issues that require medical care to cure or relieve the effects of the injury, or need to compensate the worker for residual impairment that may emanate.

There is special legislation that establishes certain medical conditions can be presumed to be job related (the presumption can be destroyed if proper evidence is not established). Some employers and adjusters do not accept the presumption or medical evidence provided that shows the medical condition is job related.

In the year of 2023 special legislation was enacted Labor Code §5814.3 which can set a substantial penalty against the self-insured employer or carrier that unreasonably rejects a claim or delay of access to medical care. The penalty of §5814.3 can reach a level of $50,000.00.

It is not unusual that the behavior of delay or denial occurs. Specific legislation of §5814.3 was enacted in year 2023 to handle these situations to motivate the adjuster to grant timely medical care.

When you have filed a claim of injury with the employer, they also have parameters that must be followed regarding acceptance or denial. The acceptance or denial can be based upon the body parts to which the injury is claimed or type of injury.

The presumptions as to the compensable exposures causing injury can go beyond the last day of work depending upon the type of disease and the development or manifestation of same.

One of the areas of concern is the delay and or denial. This can cause great harm to the worker and potentially jeopardize their health, and their ability to continue with their career forever.

The goal of the penalty provisions is to try to force the employer or third party administrator to act timely and fairly. The implementation of the labor code reflects the unintentional or intentional act to delay or

denial of the care. Labor Code §5814.3 places a high level of responsibility upon the adjuster to timely provide the necessity for care to cure or relieve. This is in addition to other penalties that can be sought.

The penalty is for unreasonable delay or denial of benefits and this has to do with injuries or illnesses as set forth in Labor Code §3212 to §3213.2. The amount of the penalty can be five times the amount of benefits that was unreasonably delayed due to rejection of the liability to a maximum level of $50,000.00.

The awareness the employer now has because of this enactment of 2023 should move them forward and avoid these delays and denials that may cause harm. Yet, even with this legislation, they at times will make these unreasonable denials. Therefore, it is imperative that when a delay or denial occurs, your attorney who is working with you is in the position to educate the employer of Labor Code §5814.3. Not only as to the penalties created and imposed, but there may be further harm to the worker forcing them to be off work longer, or delay can increase the level of residual impairment of injured worker or he/she cannot do their substantial duties and has to retire. Labor Code §5814.3 is a win approach for the employer because it forces them to have attention and provide the care pursuant to California Constitution to cure or relieve the effects of the injuries. Even with the presumptions, it is imperative that a proper foundation of evidence be presented to the treating doctor and the doctors that are determining as to whether the condition is or is not job related. Your preparation is important, without it or understanding you will allow the employer to avoid and find ways to limit the current treatment that the California Constitution and Labor Code have indicated is a necessity. The fact that you have a presumption does not remove the substantial evidence that needs to be presented to the evaluating doctor and the forensic doctors as to causative factors. Be prepared so you are not put in a position of delay or denial.

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TIME LIMITS TO OBTAIN A DISABILITY RETIREMENT

BY: SCOTT A. O'MARA

There are four major retirement systems that can provide benefits for a disability retirement that are job-related. The systems are similar, but each has a unique template that must be established within a particular timeline. The determination in regards to eligibility is also based upon different theresholds each system may have.

1. California PERS (State)
2. California PERS (Local)
3. County Retirement Act of 1937
4. City/County Retirement System (Not PERS or County Retirement Act 1937)

STATE PERS AND LOCAL PERS
(State PERS' members work for the **State of California)**
(Local PERS' members work for **smaller municipalities** and other employers that contract with PERS)

EXAMPLES OF STATE PERS:

- CHP
- Department Of Corrections
- California Department Of Forestry (CDF)
- Cal Trans
- EDD
- DMV

EXAMPLES OF LOCAL PERS:

- City of El Cajon
- City of Chula Vista
- City of National City
- Santee
- Lakeside
- La Mesa
- City of El Centro
- City of Oceanside
- City of Escondido
- City of Riverside
- County of Riverside

THE FOLLOWING EMPLOYERS **DO NOT** BELONG TO PERS:

- County of San Diego (SDCERA)
- City of San Diego (SDCERS)
- County of San Bernardino
- Imperial County
- Orange County
- City of San Diego Port District
- And other ones.

STATE PERS:

(*CHP, Department of Corrections, CDF, Cal Trans, EDD, DMV, or any state of California Emploees)*

State PERS is a retirement system within CalPERS Umbrella. A general rule is that the member should apply no later than 4 months from the last day in a paid status. The sooner the application is done the easier to move forward. The member must be permanently incapacitated from performing their duties during the entire period between last day in a paid status until the application is submitted. No personal appearance is needed to apply, applications can be made through the mail. The member must apply before termination, otherwise no application can be made. A final determination on the merits of an Industrial Disability Retirement application will not be made by PERS until resolution of labor dispute. The Effective date of retirement is: **NO EARLIER THAN THE DATE OF APPLICATION & NO LATER THAN THE LAST DAY IN A PAID STATUS.** Members are put on a fast track once any piece of the application is received by CalPERS. Once PERS receives any part of an application the member has **21 days** to complete the rest of the application. If we are waiting on doctor's statements or Work Comp info, a confirmation letter must be sent to PERS asking for a time extension. The two documents that are responsible for a delay are usually **– Doctor Statement of Incapacity** (Physician must fill out) and **Carrier Request Form** (Workers' Comp info filled out by Employer Insurance).

FACTS:

- Safety Members within the PERS system can apply for Industrial Disability Retirement (IDR). General members can apply for disability retirements but they are not entitled to the 50% tax free retirement as Safety members are.
- The **determination of incapacity** is made by **PERS** from medical findings from the treating physician or IME if deemed necessary;
- The **determination of AOE/COE** (causation) is made by the **WCAB** (Workers' Compensation Appeals Board). If there is no AOE/COE (causation) finding at time of application, PERS allows 2 years from date of application to get AOE/COE finding from WCAB;
- State PERS has the right to send member to IME if they choose;
- **WCAB Presumptions** apply to safety members;
- Can collect TTD while collecting retirement;
- Can take a service retirement pending IDR (assuming they qualify with age and years of service);
- Do not need to be P&S to apply, minimum of 12 months continued incapacity;
- Need actual work restrictions (as opposed to prophylactic WR) that preclude you from doing substantial duties;
- Determination for IDR not made until pending disciplinary action resolved in favor of employee.

LOCAL PERS:

(*Not State Employees, smaller munipalities such as: City of El Cajon, City of Chula Vista, City of National City, Santee, Lakeside, La Mesa, City of El Centro, Oceanside, City/County of Riverside, and others*)

Local PERS has no fast track system; the member is essentially applying with the employer. As soon as PERS receives an application they give notice to the employer to make a decision as to the permanent incapacity of the member within **6 months**. CalPERS adopts the recommendation of the employer as to whether the member is permanently incapacitated. A general rule is that the member should apply no more than 4 months from the last day in a paid status. The sooner the application is done the easier to move forward. The member must be permanently incapacitated from performing their duties during the entire period between last day in a paid status until the application is submitted. No personal appearance is needed to apply; applications can be made through the mail. The member must apply before termination; otherwise no application can be made. The Effective date of retirement is: **NO EARLIER THAN THE DATE OF APPLICATION & NO LATER THAN THE LAST DAY IN A PAID STATUS**. Please note that not all safety members under the Local PERS system are 3% at 50. The details of the retirement benefits may differ based upon the contract with PERS.

FACTS:

- The **determination of incapacity** is made by the Employer;
- The **determination if AOE/COE** (job-related) is made by the **WCAB** (Workers' Compensation Appeals Board. If there is no AOE/COE (causation) finding at time of application, PERS allows 2 years from date of application to get AOE/COE finding from WCAB;
- Under Local PERS, the employer has the right to send member to IME if they choose;
- **Cannot** get TTD with retirement;
- Can take a service retirement pending IDR (assuming they qualify with age and years of service);
- **WCAB Presumptions** apply to safety members;
- Do not need to be P&S to apply, minimum of 12 months of continued incapcity;
- Need actual work restrictions (as opposed to prophylactic WR) that preclude you from doing substantial duties;
- Determination for IDR not made until pending disciplinary action resolved in favor of employee.

County Retirement Act of 1937

SDCERA is an independent retirement system for employees of San Diego County. SDCERA has a longer statute of limitations in which a member can apply for a service related disability retirement. The member must be permanently incapacitated from performing his/her duties from the time of last day of paid status until application date. Members are required to **apply in person** at the SDCERA office and must have a doctor's statement of incapacity at the time of application. Safety members are allowed to service retire if they have 20 years of service regardless of age.

FACTS:

- **SDCERA** board determines if the injury is work related (AOE/COE);
- An **Independent Medical Evaluator (IME)** determines if the injury renders a disabilliiy retirement is necessary;
- All applicants are sent to an **IME**;
- SDCERA **does not** recognize the gun belt presumption;
- SDCERA **does** recognize other presumptions for safety members (cancer, heart);

- Members **must** be P&S to apply.

SAN DIEGO CITY RETIREMENT SYSTEM (SDCERS)

(*City of San Diego, Port District, Airport***)**

SDCERS is an independent retirement system for employees of the City of San Diego, Port District, and Airport Employees. The City of San Diego allows safety members to participate in the DROP program. The DROP program allows members to fix their years of service and age for retirement purposes. The member is technically service retired, but he/she is still working. The retirement funds are invested for members while they collect their full salary. The maximum time allowed in DROP is five years. Members can receive IDL, LTD, 4850 and TTD while in DROP. If the member becomes QIW (Qualified Injured Worker) while in DROP, the member can apply for disability retirement. If the DROP program is completed while the member is injured or on modified duty, the member cannot apply for IDR. The effective date is the date the member entered DROP.

FACTS:

- **SDCERS** determines if the injury is work related;
- **IME** (Independent Medical Evaluator) determines if the injury renders the member permanently incapacitated;
- **SDCERS does not** recognize WCAB presumptions;
- **Member** must apply in person;
- **Member** must apply within 4 months of last paid status or 2 years from termination if there is a continuing disability during the 2 years;
- Must be **P&S**;
- **No** psychiatric or mental disorder applications allowed unless a concurrent physical trauma to brain TBI/ traumatic event;
- If hired after **09/03/1982 cannot** have preexisting condition;
- Member can collect TD during retirement;
- Time to process application by SDCERS is 12-18 months;
- SD Port District has a presumption for COVID;
- **Industrial Death Benefit**
  This is a lifetime monthly benefit equal to ½ of the Member's Final Compensation. This death benefit is only granted if:
  - The Workers' Compensation Appeals Board determines the Active Member's death was work-related;
  - The Member has not retired or entered DROP; **and**
  - There is:
    - A surviving spouse who is also named as the Member's sole beneficiary, *or*
    - A child who is under the age of 18 (or under 21 for Port and Airport Members).

Calculation of an Industrial Disability Retirement Allowance

Government Code §21413 provides:

> Upon retirement of a local safety member for industrial disability he or she shall receive a disability retirement allowance of 50 percent of his or her final compensation plus an annuity purchased with his or her accumulated additional contributions, if any, or, if qualified for service retirement, he or she shall receive his or her service retirement allowance if the allowance, after deducting the annuity is greater.

Under provisions of the Internal Revenue Code, the disability retirement allowance of 50% of final compensation is excluded from gross income for Federal income tax purposes - - i.e., non-taxed.

26 U.S. Code §104(a), states:

> In general, except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include amounts received under workmen's compensation acts as compensation for personal injuries or sickness . . .

The disability retirement allowance of 50% of final compensation has been interpreted to be in the nature of Workers' Compensation benefits and thus is under the IRS Code exclusions.

The U.S. Tax Code which limits taxation on the first 50% of final compensation is viewed relative to the unique education experience which law enforcement officers have. This education and experience limits the transferable skills these officers have with respect to other employment opportunities and becomes very problematic for safety officers who have a job-related injury which precludes them from performing their substantial duties in law enforcement. That means that the skills, education and knowledge they have acquired in law enforcement are not going to be of assistance in obtaining post-law officer employment with another employer. Therefore, the 50% allowance constitutes recognition of the dedication that safety people have to their careers which limits their access to other employment.

(*For more information on retirement, see* www.LAW1199.com *Newsletter 2017 Issue #1 regarding the distinction between actual and prophylactic restrictions; and Newsletter 2015 Issue #3 regarding retirement considerations*.) *2022 Issue #13 Tax Trap*: https://law1199.com/wp-content/uploads/2022/11/2022-ISSUE-13.pdf

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POSTING OF WORKERS' RIGHTS FOR REPRESENTATION AB1870

BY: SCOTT A. O'MARA

The Governor signed AB1870 on 07/15/2024 which mandates employers post worker rights of legal representation for the work injury. AB1870 establishes a clear mandate that the employer post additional information regarding the employee's right for legal representation. If the employer does not follow the proper procedures to educate the employee by posting the rights for treatment, other benefits, and the added rights for legal representation, it will result in a **misdemeanor**.

Currently L.C. §3550 states:

1) How to obtain emergency medical treatment, if needed.
2) The kinds of events, injuries and illnesses covered by workers' compensation.
3) The injured employee's right to receive medical care.

AB1870 adds to L.C. §3550 as follows:

4) The injured employee may consult with a licensed attorney to advise them of their rights under workers' compensation laws. In some instances attorney fees may be paid from an injured employee's recovery.

Continuing with L.C. §3550:

5) The rights of the employee to select and change the treating physician pursuant to provisions of L.C. §4600.
6) The rights of the employee to receive temporary disability indemnity, permanent disability indemnity, supplemental job displacement and death benefits as appropriate.
7) To whom injuries should be reported.
8) The existence of time limits for the employer to be notified of an occupational injury.
9) The protections against discrimination provided pursuant to L.C. section 132a.
10) The internet website address and contact information that employees may use to obtain further information about the workers' compensation claims process and an injured

employees' rights and obligations, including the location and telephone number of the nearest Information and Assistance Officer (through the WCAB).

A significant element of the current L.C. §3550 is section (e) which states if the employer fails to provide proper notices the employee is permitted to be treated by their personal physician during the failure of not providing notice. This could be a short window but it does allow for treatment.

Labor Code §3550 and the update by AB1870 provide a more complete opportunity for the injured worker to be cured or relieved from the job related injury. Labor Code §3550 states that the information in L.C. §3550 must be "posted and keep in a conspicuous location frequented by employees, and where the notice may (be) easily read by employees during the hours of the work day". "Failure to keep any notice required by the State shall constitute a misdemeanor."

The mandate by the current L.C. §3550 and the update made by AB1870 removes some of the restraint and guilt some employers place on the injured worker's opportunity to receive medical care to cure or relieve the effects of the job related injury.

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FAMILY PROTECTION
BY: SCOTT A. O'MARA

State Senator Tom Umberg introduced Senate Bill 447 on 02/18/2025. This legislation is to amend Labor Code §4856 which provides to the surviving spouse and dependents of (a limited group) of deceased officers who was killed in the performance of his/her duties and dies as a result of this external violence or physical force performing their duties. The surviving spouse and children have entitlements to receive benefits that are particular benefits that are addressed such as health benefits provided to the survivors prior to the death. The health benefits for the children are terminated when the dependent child reaches the age of twenty-one.

Legislation change modification to Labor Code §4856 allows the coverage to continue until the child reaches the age of twenty-six.

The continuum of exposures that safety members have in their work situation is there to protect the citizens and residents of California.

This special requirement that is met by the firefighters and peace officers are a necessity for our society to continue to function.

We, the citizens of California, need to protect the groups of people that provide to us the protection we receive.

The extending from the age of twenty-one to twenty-six for the children is a reasonable benefit that California citizens need to provide to protect the family members of firefighters and police officers.

The idea is that this umbrella of protection extends to the family unit of the decedent and that this umbrella of protection provides additional benefits that are made necessary by the death of the safety member.

SB447 was signed by Governor Newsom on 10/11/2025. This law should protect all safety officers, City, County, State and other special groups.

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FAIR & EQUITABLE DISTRIBUTION OF 3RD PARTY RECOVERY

BY: SCOTT A. O'MARA

The California firefighters and California peace officers provide unlimited protection to the public. The protection they provide places the peace officers and firefighters in numerous situations of high risk and harm to them.

There are work situations where the cause of the industrial injury is by a third-party other than the employers, but in a work situation. This can be a common factor for firefighters and police officers responding to auto accident, safety protections, fires, arresting suspects, transportation of the injured public to a hospital.

The safety officers (firefighters/peace officers) may have additional remedies to assist and protect themselves in the form of a civil law suit against the harmful party causing injury. The California Supreme Court and the California Constitution states the injured worker has the right to have medical care to cure or relieve the effects of the job-related injuries, and this obligation is one that is placed upon the employer.

Parallel to this obligation that the employer has to protect the safety member, there can be additional remedies that the worker may have if a third-party other than the employer is a factor in the situation that has caused harm to the safety member. The California employer also has additional mechanisms to shift some of their economic responsibilities by exercising subrogation rights. The employer use of the subrogation system can be a shift of the employer's responsibility to provide medical care to cure or relieve the effects of the injury to the worker. The employer's use of the subrogation system can be a legal maneuver to shift all of the employer's responsibility to provide medical care to cure or relieve the effects of the injury to the workers in the recovery that was obtained from the worker's civil law suit against the entity causing the harm.

Some injuries cause high level of harm to the safety workers that go beyond the parameter of workers' compensation system, and retirement system. When this develops it may take many years for the full impact of injury to happen. The additional protection the injured worker (firefighter/peace officer) can obtain is through a civil law suit against the party causing the harm. The current unlimited subrogation legal maneuver gives the employer the ability to shift all current costs and future costs. This maneuver undermines

the firefighter/peace officer's ability to be protected against these serious damages. The employer is mandated by the California Constitution to provide medical care to cure or relieve the effects of the injury.

In some situations of the job-related injury there can be parallel litigation ongoing; one, the workers' compensation benefits and/or civil litigation against the party causing the harm. This civil litigation can be both by the injured worker and/or the employer.

The key factor in the workers' compensation system is the requirement of medical care to cure or relieve the effects of the injury. The care can be lifelong medication, can be surgery, physical therapy, and placement of the injured worker into a care facility on a lifelong basis.

Medical care does not have limitations as to the date of injury and the need for medical care. Medical care may be something that is not needed for 5-20 years from the date of injury and is not identified until a significant amount of time has passed and the development of the need for care emanates from the job-related injury. The medical care to cure or relieve the job-related injury is a paramount provision of protecting those that protect us. In addition, there is compensation that the worker can receive in the workers' compensation system, and potential compensation from pursuing the third-party cause of action.

Legislation is being offered through Senate Bill 487 by Senator Grayson that recognizes the uniqueness of the work and protection that firefighters and peace officers provide to our society. This legislation encompasses the concept that medical care is to cure or relieve the effects of the injury, and there should be no fair justification to allow that to be washed away through subrogation procedures that the employer may try and use against the firefighter/peace officer.

The legislation Senate Bill 487 recognizes the uniqueness of the firefighters and peace officers and the high level of risk and harm to them. This legislation provides guidance as to the amount of compensation that the employer can garner from exercising third-party rights to recover by usage of the subrogation system.

The employee shall receive no less than two-thirds of the third-party defendant's liability insurance policy, or coverage. This guidance as the Senate Bill 487 states is intended to reflect a fair and equitable share of the recovery in light of the injured worker's total damages, attorney's fees, and costs of the suit, and shall be deemed exclusive of any lien or offset by the employer.

The legislation which establishes the two-thirds rule states the employer shall have no right to assert any credit or offset against future medical compensation benefits owed to the employee. Once the resolution has been entered into as to the compensation to the worker, the employer can garner from a third-party one third of the damages. The two-thirds rule governs the payment to the worker.

This mandate of removing the employer’s ability to seek unreasonable compensation beyond the one-third collection protects the firefighter/peace officer.

The legislation Senate Bill 487, establishes the one-third rule and the two-third rule. Senate Bill 487 state the employer shall have no right to assert any credit, offset or denial against future medical care compensation of medical benefits. Without this specific protection language the employer could attempt to seek credit beyond one-third of the net recovery.

As stated, the future medical care is to cure or relieve and can be expansive. If the injured worker had side-effects from a medication, that could become the responsibility of the employer for the job-related injury. What may appear to be a simplistic injury may be one that evolves to a more complex medical situation that requires more surgeries, hospitalizations, and/or dependency on treatment for lifelong medical care in a facility.

This legislation, Senate Bill 487, protects the people that are protecting us. It does allow some reasonable compensation to the employer for the expenses that they have paid, but places a reasonable direction on the employer/carrier for reimbursement for ongoing medical care and costs the same. Senate Bill 487 is specific that it is to reflect a fair and equitable share of the recovery in light of the employee’s total damages, and the possible need of expanded medical care.

The legislation proposed is one that is meaningful and does not discourage the governmental entities whether that is the State, City, County or other sub-divisions from obtaining employees that will do the work of a firefighter and peace officer. We are protecting the firefighters and peace officers and ensuring that there is an equitable distribution of the monies obtained from a third-party law suit. The legislation is much needed and does provide protection to us as a society.

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FAIRNESS ACT TO RECEIVE SOCIAL SECURITY
BY: SCOTT A. O'MARA

The Social Security Fairness Act H.R. 82 passed the House of Representatives and the Senate. The Bill H.R. 82 was signed by President Joe Biden and became the law on January 5, 2025.

The Bill H.R. 82 repeals sections of the law that reduce Social Security Benefits for workers, potential workers, and their families if there was earned benefits or entitled benefits under a City, County or State Retirement System.

H.R. 82 broke down a barrier through legislation that was passed by the Government called Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) program. This was based upon many groups of employees that received, or had entitlement to receive, social security protection which was blocked off.

The WEP and GPO rules cease to be a factor in reduction of benefits that are payable on December 31, 2023 because of H.R. 82. The removal of this stone wall will allow entitlement to benefits to many workers and enhance their retirement by allowing full Social Security Benefits without being lowered by retirement benefits that they receive from the City, County or State Retirement Systems.

The Legislation impacts the benefits of many public sector employees. The Bill H.R. 82 provides many public employees access to their full security benefits, and removes the reduction of benefits because of retirement provisions and payments under the City, County or State Systems. The segment of governed employees' (City, County or State), are those that receive a pension based upon work, and are not covered by Social Security. There are several websites that can provide direction as to how to receive entitlement; one is www.ssa.gov/apply and another is www.secure.ssa.gov/INCON/main.jsp. There is an 800 number that can give you information as to potential entitlement as follows; 1(800) 772-1213.

The passage of H.R. 82 creates an economic base of security for many groups including fire, police, teachers and many other groups.

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THE LIBRARY OF INFORMATION THAT PROVIDES YOU WITH PROTECTION

BY: SCOTT A. O'MARA

In the Library of Information at website *Law1199.com* there are numerous articles that review the workers' compensation, retirement and impact of an injury, medical care, levels of disability, continued employment and forms of communication.

These articles are a source of information to garner pathways that can be utilized to obtain and protect medical care and other benefits.

Article 2021, Issue #12 titled *Knowledge is Power for Treatment* specifies the recognition that the worker must have an awareness of the two types of injuries that the workers' compensation system has embraced; specific and cumulative trauma. The awareness of those injuries and the mechanism or possible injuries is helpful for the worker to appreciate the factors of employment that may be contributing to a job-related injury.

There are different doctors utilized in the workers' compensation system, a treating doctor and a forensic type doctor. The forensic doctor evaluates the etiology of the injury and comments upon the need for time off, need for returning back to work, levels of impairment and whether the worker can continue with their employment.

In the *2021 Newsletter #12, Knowledge Is Power For Treatment*, acknowledgment that there are some doctors that are engaging in what is called "catch and release programs". They quickly do their evaluation, review records and go in and release the worker from the office. This enhances the income flow for the doctor. This is not the case in all situations, but does exist. If the worker is prepared to cover certain areas such as the mechanism of injury, whether it is a specific or a cumulative trauma the worker can articulate to the doctor those factors. Those factors are the foundation of whether the medical condition is or is not job-related. Therefore, preparation prior to the treatment and/or the forensic evaluations is important to ensure these elements are covered.

In the *Newsletter 2022, Issue #11* titled *Balanced Communication with the Doctor* reflects that the treating doctor indeed does have a different role than the forensic doctor. The treating doctor and the forensic evaluation physician will use the subjective complaints as articulated by the worker, look at the objective findings and then derive their diagnoses and potentially forms of treatment.

Subjective comments are the worker's perception as to typically the pain and discomfort that they have and what may make the subjective complaints less prominent, such as forms of treatment.

Therefore, the worker's part of their evaluation should have a broad spectrum as to what pain and discomfort they have. And, typically as articulated the pain and discomfort can vary with good days and bad days. Expressing the good days and bad days creates a wall of protection regarding veracity. The failure that occurs at times is the worker will only focus on the bad days and if that is the case, that allows the adjusting agency to seek out a review as to the veracity by showing there are factors of other activities that the worker does on a good day but did not share that with the all the doctors, treating and forensic.

The key element is not to overstate or understate the subjective complaints, but a balanced communication as to what you can or cannot do, or what you have to modify.

The balanced communication is with the forensic evaluators and the treaters. Prior to meeting with the treater or the evaluators the worker should give thought as to good days and bad days and the articulation of same.

In addition to the awareness of your subjective complaints it is important to articulate with the doctor and staff that there is a cordial relationship. If the worker goes into the office and is angry, hostile and has a belligerent attitude towards the doctor and staff, this will unfortunately color the report in a manner that is not helpful. It is not that the doctor is trying to get back at the injured worker, but it can impact their perspective.

In *Article 2024, Issue #7* titled *Impacts on Medical Care, Employment and Disability*. This reinforces the idea of the relationship of a good communication with the treating or examining doctors and their staff. This element will allow the doctor and staff to garner a complete history of the mechanism of injury, the subjective complaints, what the worker can or cannot do, and what they have to modify. The impact is on the medical care, time off of work, and residual impairment, and the very important history of pain and limit on good days and bad days.

The medical care by the California Constitution is to cure or relieve the effects of the job-related injury; this medical care can be expansive and lifelong.

The next article is *2023, Issue #9* titled *Medical Care for Preexisting Conditions*. If the worker had a condition that existed prior to the job-related injury and that medical condition becomes more symptomatic due to the injury or treatment from the injury, this may be the responsibility of the employer to provide for the care needed that emanated from the injury, and provide care due to increased and/or changes to a preexisting condition because of the job-related injury.

In your preparation review the website called WebMD. The website has an area where you can look up the medications that you are taking and look for the side effects. Therefore if you are taking a medication for the job-related injury and you have the side effects from that medication that you are taking, it would be appropriate to share that information with the doctor if there are side effects. By doing so, the doctor can articulate that and if that condition continues to be more problematic or you need to continue with the care this could award you lifetime medical on that condition caused or made worse by the job-related medication.

Recently, we had the case that was resolved many years ago, and we advised the client that there is the right of five years to open the case from the date of injury. In this situation, the condition became more symptomatic. The client advised us of that and we filed a Petition to Reopen for New and Further Disability. Unfortunately for the client there has been a change in disability, he will receive additional compensation for that because he gave us the appropriate information which was that the condition had become more symptomatic since we resolved the case, and the information was provided within the five year window. (*2019, Issue #1 Protection for Injured Workers' Under the Five-Year Window*)

There are certain medical conditions in which we can get a special order from the court that grants the condition is insidious and progressive. These typically are cancer cases. If the court grants an order that the condition is insidious and progressive there is no five year limitation. If there is a court finding that is an insidious and progressive and the jurisdiction is reserved there is no limitation to reopen the case. Reopening the case goes to the level of impairment, we do not need to have the benefit of reopening the case to increase the level of medical care. But if having the medical care increased and it is within that five year limit there is a high probability that there is an increase in permanent disability. Therefore you will receive a letter from us indicating that you have a five year window. (*2019, Issue #1 Protection for Injured Workers' Under the Five-Year Window Insidious and Progressive*)

An awareness as to the five year window is set forth in *Newsletter Article 2021, Issue #6*. Besides the current information there are many articles that are written that come back with studies indicating that there may be additional changes in the medical care. In *Newsletter Article 2024, Issue #14* a new study has come out and is one that the International Association of Research on Cancer has found that certain types of medications can be a carcinogen and a carcinogen is a factor in causing cancer. In that study that they have done indicates that there are medications

taken for hypertension indeed can be a carcinogen. It is important that as you become aware of this you share that with your doctor. The doctors may not be in a position where they want to embrace it because it is a new article, but you are putting them on notice. You need to monitor what is going on with your health, and if in fact there is a change such as the cancer causing factor, this could be brought within the workers' compensation if the hypertension medication that you are taking is because of a job-related injury.

In *Newsletter Article 2024, Issue #14* titled *Can Medication For Hypertension Be A Factor In Causing Cancer* there is a discussion that you should go to WebMD and look at the risk factors and side effects of medications.

Your preparation is paramount regarding your ability to communicate with the doctor. Your understanding as to the subjective factors and not overstating, but not understating, is also a significant element. The relationship that you have with the treating doctor and staff is a factor that helps the doctor to move forward to provide with medical care to cure or relieve.

The physicians are not paid additional compensation to go into in-depth studies. If the doctor and the staff like their patients, there is an emotional motivation that they could take additional steps necessary to get the medical care to cure or relieve the effects of the injury. Knowledge is the power for treatment, knowledge is the power to show that the condition is job-related, knowledge is the power to either continue with your employment or be in a position where you can garner a disability retirement. Knowledge is something that will develop the case and your understanding in grasping of same makes more effective communication.

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