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2026 ★ ISSUE #1

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MEDICAL TREATMENT NOT ACCEPTED BY THE INJURED WORKER (ADJUSTER USES "GHOST DOCTORS")

BY: SCOTT A. O'MARA

The California Constitution specifically states that the workers' compensation laws mandate that in the event of a job-related injury the employer is to provide medical care to cure or relieve the effects of the job related injury.

With the changes in the Workers' Compensation System there are some very difficult protocols that the injured worker has to follow to obtain the medical care. The injured worker's doctor has to provide a request for authorization (RFA) to the adjuster to provide the medical care. The treating doctor's request for medical treatment is placed on a form called Request for Authorization (RFA). The adjuster will then send this form to an outside doctor that is paid for by the employer. This doctor does not see the patient. The UR doctor reviews the recommendations by treating doctor, and if authorized the case will go forward with the treatment. If the treatment is denied by the Utilization Review doctor the worker has a very limited opportunity to challenge this by going to Independent Medical Review. Independent Medical Review "Ghost Doctors" do not see the patient nor are the parties allowed to know who the Independent Medical Review "Ghost Doctors" are. The case law and statute indicates that if there is a denial or limit of medical care this process supports the denial by UR and IMR, the worker may be stuck with limited medical care or no medical care for the next 12 months.

There are delays and frustration that occur in the system that has caused some workers to decide they do not want to participate or try to receive the medical care by going through the RFA process and the UR process. The UR and IMR process can cause the delay and limitation of care.

There is another harmful tool available to the employer to attempt to lower their cost and responsibility for treatment and for a disability retirement. This is set forth in Labor Code §4056 which states that if there is a disability or a need for retirement that has developed because of the worker's refusal of the medical care and the refusal is unreasonable and this medical condition is aggravated or made worse by the worker's refusal, the employer is no longer responsible for workers' compensation care in that area. If the retirement is mandated because of the worker's refusal treatment this is a tool to deny the disability retirement.

The doctors that the employer utilizes in Utilization Review and the potential avoidability of a consequence of care are the tools that the employer can utilize again to limit their cost in the need to provide medical care or grant a disability retirement.

This awareness that the employer uses is a cost limitation tool. This cost limitation tool is contrary to what the California Constitution states. Labor Code §4056 embraces this wall of denial and limitation of benefits. You as a California employee need to be aware as to the importance of your communications with the treating doctor and the staff. Whether it is trying to expand the medical care beyond what Utilization Review and IMR, or not embracing the medical care that is allegedly approved by Utilization Review and IMR. If you have a treating doctor that articulates the rationales for either another approach on care or not going that route, you are providing a potential blanket of protection against the harm that Labor Code §4056 has created. There are certain situations where the worker has elected not to go the route of the medical care and seeks out the disability retirement and the court has come back and indicated that the non-acceptance of the medical care can be the reason to deny the disability retirement.

You as the California worker need knowledge and understanding, you need to communicate with your treating doctor. If in fact your treating doctor concurs as to the route of care that you want to proceed on verses what is being pushed by "Ghost Doctors", this could give you a blanket of protection. Without this your vulnerability is very high and the employer or the administrative retirement systems can and will use this as a tool to remove their obligations that they have pursuant to the Government Code and the California Constitution. Preparation is imperative; discussion with your treating doctors is imperative and communication to your attorney to ensure that the elements are there to help provide you with protection.

It is a common element for the patient to have concerns regarding the impact of treatment and potential side effects of treatment i.e. the surgery or medication that is utilized post the treatment.

There is a website called WEBMD that provides a list of all medications that people utilize. This website also talks about the side effects. The side effects of the medications change as to who the patient is, and what their history is. Many patients are aware that the authorized surgery will have side effects. They gather the knowledge either from family members, or from their friends. Their concern is not to have the condition worsen, as there is, no guarantee offered at any time that the surgery indeed would make corrective measures and not cause side effects at a level greater than what is currently there.

The doctors that engage in the workers' compensation protocol, whether it is the Utilization Review doctors or IMR doctors, are "Ghost Doctors". Many times these doctors engage in what is called the "catch and release program". This is where they look at the documents quickly, or have their subordinates' (non-medical doctors), look at the documents and then make their findings based upon that, all without seeing the patients. The concept that an approval or denial of medical care can be made without seeing the patient is a problem that is a high risk for the patient.

The “catch and release program” for some doctors is they want a volume of cases coming in. They catch the case, look at it quickly and release it, and get paid compensation for their opinion.

It is not uncommon for some patients that have friends and family that have had similar treatments offered that causes side effects.

The current system is a risk factor that the patient needs to be aware of. The legislation that was passed in Labor Code §4056 is again a tool to lower costs on job related injuries. This needs to be removed and more information needs to be provided to the patient so that they can make a reasonable decision for the care, and not have a threat of losing benefits such as treatment and/or retirement.

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AB 1054 (Gipson (A) - Introduced 02/20/2025, amended 03/24/2025)

BY: SCOTT A. O'MARA & DANIEL J. PALASCIANO

AB 1054 was introduced earlier this year by Assemblyman Gipson, as an attempt to establish a Deferred Retirement Option Program (DROP) for CHP Officers and CalFire firefighters. The initial version of the bill introduced on 02/20/2025 was essentially an outline of the proposal to create the DROP system, however, there were no specifics as to how the DROP system would be set up, eligibility requirements, etc. That bill was referred to the Assembly Committee on Public Employment and Retirement ("Committee") on 03/24/2025.

On that same date, an amended version of AB 1054, which was nearly identical to the initial bill, was recommended for re-referral to the Committee, and on 03/25/2025, the bill was re-referred to the Committee. However, a hearing before the Committee scheduled for 04/23/2025 was cancelled at the request of Assemblyman Gipson. No action has been taken on this bill since that time.

Prior to the cancelled P.E. & R committee hearing, there were proposed draft amendments to the bill that were circulated which were dated 03/24/2025. These draft amendments provided a version of the details about how the DROP system would operate, eligibility requirements, etc., that went far beyond the general intent statements of the first two versions of AB 1054.

While not adopted as part of the currently amended version of AB 1054, the draft amendments shine much light on the proposed workings of a DROP system. For example, included in the draft amendments is proposed Government Code §21717.8 (a)(2), which reads as follows:

> (2) The member must waive and forfeit any application, claim, or right to any disability retirement benefit administered by any public retirement system of which they are a member, and where such an application, claim, or right to any disability retirement benefit is based on a condition relating to an illness of injury that occurred prior to their election to participate in the program, regardless of whether the illness or injury is industrial or nonindustrial.

While the language of this proposed section is not a model of clarity, it seems clear that the intent of this section is to prevent a CHP Officer or CalFire member who is in DROP from applying for an Industrial Disability Retirement (IDR) when the basis of that application relates to any injury or illness that occurred prior to the member's decision to participate in DROP. This section is problematic for multiple reasons.

As a reminder, per Section 1 of AB 1054, the main intent of the proposed DROP program, as stated by the Legislature, is to encourage CHP and CalFire members to work beyond their planned service retirement date, due to the, **"deficiency in the recruitment and retention of CHP officers and CAL FIRE firefighters which has resulted in a chronic shortage of needed personnel(.)**" The Legislature goes on to state that, "**the challenges now being confronted by both the CHP and CAL FIRE are dangerously protracted requiring increasing reliance on existing experiences and expertise.**" Further, the Legislature has found that the CHP now serves as a local and statewide law enforcement entity, and the Legislature further declares that CAL FIRE's handling of catastrophic disasters in the "new normal", and has significantly increased the complexity of its mission.

In response to this "deficiency in recruitment and retention" of qualified personnel, the DROP program has been introduced, which would increase not only the amount of available personnel for both agencies, but would specifically increase the amount of thoroughly trained, highly experienced personnel, at a time when the State of California is in dire need of such personnel.

Unfortunately, proposed Government Code §21717.8(a)(2) would most likely frustrate the intent of the DROP system, by deterring qualified personnel from electing to participate in DROP. This is because while many experienced CHP officers and CalFire firefighters have had injuries during their career, the vast majority of on-the-job injuries are successfully treated, and the injured worker returns to full duty, oftentimes for years without incident.

For example, a CHP Officer with a non-surgical back injury may be injured early in their career, get successfully treated, and then work for another 15 or 20 years in good health up until their planned service retirement date. That Officer then enters DROP and continues with his full duties. If that Officer suffers a second back injury while working in DROP that renders them unable to do their usual and customary duties, why should that Officer be barred for applying for an IDR?

Again, having such a condition put upon CHP Officers and CalFire firefighters *would likely dissuade them from opting into the DROP program*. If our CHP Officers above were to be injured on the job while working in DROP and was no longer able to work, he would not only lose the ability to continue working in the DROP program, with its concomitant financial benefits, but he would also be unable to apply for an IDR, which provides a significant tax benefit to safety personnel injured on the job. Especially if our CHP Officer were injured to the extent that they could no longer work at any job, their financial harm would be even greater.

Further, there does not appear to be a valid rationale to counter this argument. The benefit conferred by the IDR is a federal tax benefit, which does not cost the State of California anything. The State of California is not required to increase the member's retirement allowance, or contribute anything at all to the increased benefit that would come to a DROP member who was granted an IDR. The only additional benefit conferred on an IDR recipient who was injured while in DROP comes through the federal government, not the State of California.

At such time as AB 1054 or another DROP bill becomes active in Sacramento, attention must be paid to the details of any such bill, especially if a provision such as the current proposed Government Code §21717.8(a)(2) is included. Based on the foregoing, it is clear there is no rational basis for AB 1054 or an updated DROP bill to include Government Code §21717.8 (a)(2). The only potential effect this section would have on the DROP system would be to deter from the DROP program many qualified and experienced personnel that AB 1054 is attempting to persuade to keep working in the first place.

It continues to be very important to monitor the maturation of AB 1054 to insure that the legislature does not penalize those officers and firefighters who participate in DROP by negatively impacting their right to an IDR. It will be difficult to create a meaningful solution to the current staffing crisis unless AB 1054 is eventually passed in a manner that does not cause harm to CHP Officers and CalFire firefighters. One way to prevent such harm is to make sure that currently proposed Government Code §21717.8(a)(2), or any similar such provision, is not included in the final legislation.

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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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GHOST DOCTORS AND THEIR ROLE AS A JUDGE

BY: SCOTT A. O'MARA

JUSTICE

The California Constitution (Article 14, Section 4) sets forth the workers' compensation system and Labor Code §4600 is to provide for a complete medical treatment system to cure or relieve the effects of the worker's injuries. This treatment shall be provided by the employer.

CHECKS & BALANCE

The workers compensation system had a Checks and Balance System which was lost by Senate Bill 899. This System was to protect the worker's rights to obtain medical care to cure or relieve the effects of the worker's injuries.

The workers' compensation system was drastically damaged by SB899 signed into law by Governor Schwarzenegger on 04/19/2004.

However, important elements of the law remained after SB899:

a) The workers' compensation Judges are independent of all parties and are subject to review of their findings.

b) The judges are objective and separated from the employer and employee. No payments are made to them by either party. The judges have a code of judicial ethics and are required to be licensed by the California State Bar and have good standing.

If the injured worker or employer has issues with the medical treatment needed to cure or relieve the job related injury, the worker had the right to present evidence to the independent judge on that issue.

This basic right has been severely limited and removed by SB863, signed into law by Governor Brown in 2012. SB863 replaced independent judges with an IMR process where "Ghost doctors" now make crucial decisions regarding denied medical care, instead of independent judges. The IMR doctors (Ghost doctors) are not required to provide any significant information as to the

status of their medical license. The IMR doctors, (Ghost doctors), never actually sees or examines the injured worker.

Medical doctors who practice in California and who provide medical care to the injured worker are required to be holding a California license and be in good standing. The Medical Board of California provides information as to the physicians' profile, types of license and standing regarding that license, whether their license has been cancelled or suspended. The IMR doctors (Ghost doctors) do not have this standard of disclosure.

This information as to the licensing status of the treating doctor is a necessity for the determination as to the value of their medical opinion. Additional is the review of the information/evidence that is examined by the treating doctor and the basis for their findings as to what medical care is needed or not needed to cure or relieve the effects of the injury. There is a high standard for examination of the information/evidence that has been reviewed by the Treating doctor and the basis for determination as to what additional medical care is needed or not need to cure or relieve the effects of the injury. The IMR doctors (Ghost doctors) are not subject to review regarding the medical information reviewed and granting or denying medical care. The checks and balance should be placed on the IMR doctor (Ghost doctors). The IMR doctor (Ghost doctors) is paid for by the employer or the insurance company. Judges are not paid for by the employer, insurance company or the employee. The parties need to be aware of the IMR doctor's (Ghost doctors) medical license and current status of same, whether there are limitations on the license, a suspension of the license, or if it has been removed. This is a significant element of the Checks and Balances. The parties need to know what the medical evidence that is used by the IMR doctor (Ghost doctors), whether it be testing or other materials and what their reliance was upon for the finding, denying, limiting or granting medical care. Note that the IMR doctor (Ghost doctors) never sees or examines the injured worker and does not make a full disclosure as to the medical documents and records examined.

ACCOUNTABILITY

The current UR/IMR system does not have accountability because of lack of information and the removal of an independent workers' compensation judge. The IMR doctor (Ghost doctors), has been put in the place of the workers' compensation judge. The use of UR/IMR (Ghost doctor) system was not seen at the time of implementation as a veil of secrecy or a substantial problem. However, this UR/IMR system has discouraged some California licensed doctors from continuing to provide medical care to cure or relieve the effects of the injury because of the opinions of the IMR doctors (Ghost doctors) is not subject to transparency, and because the system creates additional obligations on the treating doctors to justify their medical care. In addition there are many times where there is a disparity between the treating physicians' expertise in a particular area of medicine that is lacking in UR/IMR doctor's (Ghost doctor's) education or areas of specialty. Therefore, there is a lack of substantial evidence regarding the reliability of UR/IMR doctor (Ghost doctors) opinion. This lack of expertise and/or evidence cannot be presented to an independent judge, again, because of the legislative enactment of SB863. There is a view that the changing the current IMR (Ghost doctor) system is going to further discourage the real treating doctors from providing treatment. This is a misunderstanding.

The modification proposed (www.law1199.com *Newsletter 2019, Issue #3*) will allow the treating doctor a greater opportunity to provide the proper treatment to cure or relieve the effects of the injury with fewer encumbrances placed upon them based upon an alleged medical opinion of the UR/IMR (Ghost doctor). The medical opinions of the UR/IMR (Ghost doctors) are not subject to checks and balance and are not objective because of the lack of physical examination by an IMR doctor. In addition the UR/IMR doctors are paid by the employer.

EQUALITY

The modifications required will provide more equality. The judges are not paid for by the employer such as the IMR (Ghost doctors) are. All parties are aware that the IMR doctor is a Ghost and not required to be licensed in California and is not subject to checks and balances as to what the substantial evidence is used for his/her opinion. The opinions of the Treating doctor, UR doctor or the IMR (Ghost doctors) must be subject to review by and an independent judge not an IMR doctor who acts in the role of a judge.

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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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THE WAIVER RISK

BY: SCOTT A. O'MARA

The CalPERS, County retirement and the City retirement systems all have a secondary re-evaluation procedure for Workers that retire early because of an industrial disability retirement.

This allows the retirement system to compel the Worker (that have a job-related injury, and was forced to leave their employment because of the complications due to the injury and their inability to perform the substantial duties of a job) to undergo a re-evaluation allowing the governmental entity to force a re-evaluation.

There is a practice that some Employer's use to manipulate the Workers and remove the Worker's ability to return back to work. This is done by getting the Worker to sign a settlement document in the Workers' Compensation cases that state that, "the Worker was waiving their right to return back to employment". That if the Worker was to attempt to return back to work either forcibly, by the retirement system, or on their own unilateral decision that the worker has agreed to waive their rights to be rehired.

The Workers' Compensation settlement documents which set forth this waiver create a significant complication for the Worker.

The caveat to the Worker is the understanding that the Compromise and Release (C&R) although it only speaks to the Workers' Compensation system it can override and dictate removing the Workers' right for returning and reinstatement with the Employer.

Without this specific language of a waiver in the C&R of re-employment where the Worker agreed that the lump-sum settlement is also a waiver of any right to reinstatement or be rehired, and the Worker agrees not to seek reinstatement with the Employer or agrees to not reapply for employment with the Employer, without that language, if a determination was made by either CalPERS, the governmental agencies that fall within the County Retirement Act of 1937 and/or the majority of the retirement systems the Worker if found eligible, physically or mentally and they were able to return back to work based upon the Employer having an available position they could then do same, if no waiver.

There is an interesting case that I litigated many years ago and in that situation, the Worker or Sergeant in Highway Patrol sought to return back to work with the Department. The Department and State Compensation Insurance Fund told him he did not have right for reinstatement regardless of his medical condition improving and was supported by the documentation provided by the doctors. The Employer denied the employment.

That was litigated and it was determined that the Employer did not have the right to deny re-employment. The determination as to returning back to work as this was to be made by CalPERS.

CalPERS made the Decision, and the employer was forced to allow Sergeant Starnes to return back to work because he had not done a waiver.

Sergeant Willie Starnes in his Worker Comp. case with his employer did not waive his right to return back to work. Instead, Sergeant Willie Starnes entered in to a Stipulation which gave him five (5) years from the date of injury to Reopen the case for New and Further Disability, and lifetime medical care, leaving open the option of his ability to return back to work.

The other tool for resolution of a case without litigation is a Compromise and Release (C&R) and many Employers' because of the frustration the Workers' are running into because of the failure of the Utilization Review (UR) and Industrial Medical Review (IMR) offer a Compromise and Release (C&R). The Compromise and Release (C&R) is a lump-sum payment where the Worker agrees to give up their right to receive any future medical care and waiver of Reopening rights for New and Further Disability. In addition to the waiver of medical care and right to Reopen for New and Further Disability, the verbiage that is now being utilized by some Employers' in a Compromise and Release (C&R) is the waiver of the ability to be able to be employed again by either reinstatement and/or rehire.

The caveat is that the Worker needs to speak to their Attorney. Many times, I have seen this particular documentation occur where the Worker has waived their rights to reinstatement because the Worker has **not** had representation. The Worker does not understand the multi-prong approach that can be utilized if their condition changes and **allows the Employer to remove the disability retirement**, **and allows the Employer to not oblige to re-employ the Worker by this waiver that has been set forth in the settlement document.**

It has been previously litigated unsuccessfully by other law firms that the waiver verbiage used was a violation of the Labor Code 132(a), and was discriminatory to the Worker. The Worker in the waiver had not anticipated that their condition would improve nor had the Worker anticipated that the Employers' retirement system would seek to remove the retirement income, if in fact, the medical evidence supported the return to work.

In the cases that are utilized to justify the waiver it was found that the resignation, was voluntary. The resignation, waiver even though it was stepped outside of the Workers' Compensation arena had binding affect on the retirement system, and the injured worker. Even though the retirement system had not been brought into the case, other than, after the waiver had occurred the Worker was stopped from the ability to obtain reinstatement because the Worker had signed a waiver of rights to his/her reinstatement.
The language used in the settlement documents should be limited solely to the Workers' Compensation system. If the settlement document steps outside of those parameters, the Worker and Counsel should examine the risk to the Worker as well as examine the Compromise and Release (C&R) and its substantial impact way beyond the Workers' Compensation arena.
The Employers' usage and manipulation of this is very troubling. Particularly, when the Worker does not have counsel to represent their best interests and the Employer understands the legal significance of this waiver while the worker does not understand a waiver precludes the option of returning back to work.

We do not recommend the Compromise and Release (C&R) in the vast majority of the cases, even though there are some mounting problems because of the denial, timely medical care with Utilization Review and Independent Medical Review. The waiver that is placed on the Compromise and Release (C&R) is set up in a position where the Worker gives up their right for medical care, and if the Employer manipulates the retirement system or the retirement system steps in, and if the Worker loses the ability for the disability retirement they are not be in a position to obtain reinstatement because of the waiver.

If the reinstatement system is still used because of no waiver, the Employers may not seek to curtail or deny the Workers right to return back to work due concerns that the employer has the injured Worker may become a higher risk of re-injury. The worker has right to return to work if

there was no waiver made and the medical evidence supports the ability to return to work. (*Willie Starnes case)*

This right to return back to work if there is no waiver was set forth in the *Phillips v County of Fresno* case. In that matter, the County Retirement Board determined there was no residual impairment precluding him from returning back to work. But yet, the Employer delayed the Workers returning back to work and delayed making payments to him. The court ultimately opined in a court of Appellate Decision in 1990, that the County was obliged to allow him to return back to work within at least thirty (30) days of the denial. Once the Worker sought the ability to return to work and that the County's continued delay and the County's not paying him money during this period of time there was an obligation that the County had. Therefore, the County was ordered to meet this obligation by paying from February 1984 to January 1987, which included his salary, vacation credits, annual leave credits, and retirement contributions. The Opinion was based upon the reinstatement rights that were retroactive with back pay and benefits. Again, the *Phillips* case is supportive as to why the member should not engage in a waiver that may impact their employment and/or income at later stage, if in fact the disability retirement is found to be not medically necessary or the workers condition improves allowing him/her to return to work.

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UNDERSTANDING THE RETIREMENT SYSTEM AND THE IMPORTANT DISTINCTION BETWEEN ACTUAL AND PROPHYLACTIC RESTRICTIONS

BY: SCOTT A. O'MARA

The State of California and other governmental entities — such as the counties, school districts, college districts and cities — recognize the unique work associated with law enforcement, along with the unique harmful exposures of that occupation. This work requires special education and training which is limited in its transferability to other employment opportunities they might pursue post their work in law enforcement. This fact has been recognized in the provision of benefits under disability retirement systems for workers who have a condition which is job-related and precludes them from being able to perform their substantial duties in law enforcement.

By and large, disability retirement systems benefit both injured officers, by providing an economic blanket of security when a work injury impairs their ability to perform their law enforcement activities, and society, by encouraging and allowing the law enforcement field to bring in high-caliber people to perform law enforcement activities.

At times, the Workers' Compensation system has an overlay with retirement systems, as some retirement systems will accept the Work Comp system's determination as to whether a worker's condition is or is not job-related, while other retirement systems have their own independent standards to determine causal factors in relation to a worker's employment.

An unfortunate theme which is used from time to time by all agencies — whether it is the State, a county, a city or a particular district — is the attempt to intimidate workers who sustain a job-related injury. In these instances, the protocol is to utilize the level of residual impairment as an indicator as to whether a worker can or cannot perform his or her substantial duties. This threat is used to dissuade and discourage some safety workers from seeking benefits to which they are rightfully entitled under the Workers' Compensation system. The fear is that if they go forward and file a Work Comp case, and their level of impairment is a number which is not acceptable to the employer, the employer may use this figure as a vehicle to force the worker into a disability retirement.

A disability retirement may only be granted when certain parameters are met. One of the most significant parameters is whether the restrictions imposed by the worker's doctor in relation to a worker's disability are actual or prophylactic. An actual restriction means the worker is unable to perform a particular activity, while a prophylactic restriction means the worker can perform the activity, but doing so may cause discomfort or produce other symptomatology. Thus, a critical factor is whether the worker's impairment clearly precludes the ability to perform a particular activity, or whether it simply is a matter of the activity causing discomfort. An important factor also is whether the activity in question is crucial to the worker being able to perform his/her substantial duties.

A second factor sometimes used by employers to force a worker into a disability retirement when he/she has merely a prophylactic restriction is the assumption that based on the current level of a worker's medical problems, continuing to perform any activities in question will place the worker at increased risk of further injury. This in itself does not create the medical necessity for a disability retirement. Case law has reviewed and considered this issue, and safety members need to be aware of the very significant difference between actual and prophylactic restrictions.

The vast majority of safety workers — in fact, over 95 percent — want to continue with their careers after a work injury. However, when faced with this decision, officers need to consider three elements — their health, their family and their career. If a worker's health jeopardizes their family relationship, they should give consideration as to whether they want to retire. If the worker decides to pursue a retirement based on disability which is defined in terms of a prophylactic restriction, the retirement will *not* be granted. The same holds true if the employer is the party seeking to force a worker's retirement — they cannot do so successfully if the worker's restrictions are merely prophylactic.

The next factor to consider is the worker's usual and customary duties, which can change from time to time. In fact, there are many situations where a safety officer can continue to perform his/her work because the restrictions imposed do not significantly impact the worker's ability to perform his/her usual and customary duties.

Therefore, safety workers who feel threatened by the possibility of losing their employment (and their employability) because of having filed a Workers' Compensation case should speak with their doctor and attorney to learn whether their restrictions are actual or prophylactic. As noted above, if the restrictions are prophylactic, that allows great latitude for the worker to continue with his/her employment.

On the other hand, if the restrictions are actual, then the ordered priority of health, family, career needs to be considered. If successful modifications can be made, an injured worker can then potentially continue with his/her career. However, if such modifications cannot be made, the venue of a disability retirement protects them and our society as well.

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 was 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.

Restoring health is an injured worker's foremost goal. Therefore, it is important that workers who hesitate to file a Workers' Compensation case (and obtain the health care they need) based on the fear of losing their jobs should be aware that although some employers might attempt to force them out, they cannot do so when the worker's restrictions are merely prophylactic.

Many employers will determine a worker cannot perform his/her substantial duties because of the level of permanent impairment resulting from a job-related injury. Permanent impairment is determined by three factors: the injured body part or medical condition; the worker's occupation; and the worker's age. These factors are placed into a formula which ultimately produces a percentage value of impairment.

The determination as to impairment is based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. In this 613-page book, the authors set forth that the impairment evaluation is only one aspect of the disability determination. Other factors include the injured worker's skills, education, job history, adaptability and age, as well as environmental requirements and modifications. Of significance is that the *AMA Guides* specifically state:

> *"Impairment percentages derived from the Guides criteria should not be used as direct estimates of disability. Impairment percentages estimate the extent of the impairment on whole person functioning and account for basic activities of daily living, not including work. The complexity of work activities requires individual analyses. Impairment assessment is a necessary first step in determining disability."*

This paragraph makes clear and concise that levels of impairment in the *Guides* are not directive as to whether a worker can or cannot perform his or her substantial duties.

As previously articulated, restrictions, for retirement purposes, must be *actual*, not *prophylactic*. The Physician's Report on Disability, which must be completed by the injured worker's physician as part of the CalPERS Disability Retirement Election Application, is very direct and consistent with the case law established by the *Willie Starnes* case when the Report states on page 2:

"To qualify for a disability retirement, the CalPERS member must be substantially incapacitated from the performance of the usual duties of his/her position with the current employer. This 'substantial incapacity' must be due to a medical condition of permanent or extended and uncertain duration. Disability is not necessarily an inability to perform fully every function of a given position. Rather, the courts have concluded that the test is whether the member has a substantial inability to perform the usual and customary duties of the position."

The paragraph concludes with this highlighted statement:

"Prophylactic restrictions are not a basis for a disability retirement."

Again, this statement is very direct in setting forth that a prophylactic restriction is *not* a sufficient basis for either granting a disability retirement or forcing a worker to retire. Therefore, the use by some employers of prophylactic restrictions and the level of permanent impairment as justification for the determination that a worker is unable to perform his/her substantial duties is inappropriate and inconsistent with established case law.

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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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MODEL OPTIONS/CONTACT LETTER

Date

Name
Address
Address

Dear Mr./Ms.

The Department is in receipt of the [DATE] medical report of [DOCTOR'S NAME] which indicates that you are unable to perform the duties of your current position, [JOB TITLE], with this department. Therefore the following information is being provided for you to let you know of the various options which may be available to you. We invite you to engage with us in an interactive process to begin to develop an appropriate plan for resolving the issues raised in this report.

Please contact me by [DATE] to set up a meeting to discuss these options. Failure to do so may result in the department selecting an option for you.

1. Return to Work

Full duty: You may be able to return to work as a [JOB TITLE] performing full duty with no restrictions, if you provide a full medical release, in writing, from your treating physician. This medical release must be provided prior to your return to work.

Reasonable Accommodation: If you believe that you are disabled and that a reasonable accommodation would enable you to perform the essential functions of your current position/classification, you may request a reasonable accommodation. If you are qualified and would like to pursue an alternate placement to another classification, for which you meet the minimum qualifications, a list of current job vacancies will be provided to you. You may indicate which positions you are interested in and you will be given an opportunity to demonstrate your qualifications for those positions.

Medical Transfer/Demotion: If you are unable to perform the work of your current position, but are able to perform the work of another position in the Department, you may be able to medically transfer or medically demote to such a position. If at a later date you are no longer incapacitated for duty in your original position, under most circumstances, you would have a mandatory right to reinstatement to that classification or an equivalent classification. This option is available through the provisions of Government Code section 19253.5.

2. Temporary Leave

Family Medical Leave Act (FMLA)/California Family Rights Act (CFRA): If you qualify, you may request a leave of absence under either of these statutes. Both allow qualified employees to take up to 12 weeks of unpaid leave each year when they, or a qualified family member, have a serious health condition. You may be able to utilize existing leave credits. These statutes require that the employer maintain an employee's health, dental and vision coverage during such leave.

Pregnancy Disability Leave: If you are unable to perform in your current position due to a disability related to pregnancy, you may be entitled to unpaid leave. Accrued leave credits may be available to supplement this leave.

Medical Leave of Absence: You may request an unpaid medical leave of absence for up to one year. Under this option, the employer is not required to maintain an employee's heath, dental and vision coverage. You may choose to pay for these benefits yourself.

Leave Balances: You may be able to utilize existing leave balances, including a request for catastrophic leave.

Temporary Assignment: A temporary assignment or loan of employees within an agency or between agencies not to exceed two years may be available to facilitate your return to work. You would have a mandatory right to return to your former position should this option be exercised.

Non-Industrial Disability Insurance (NDI): If you have a non-industrial health condition, or a denied Workers' Compensation claim, which prevents you from working you may be entitled to NDI benefits. The NDI benefit is administered by the Employment Development Department (EDD). Your doctor must provide medical substantiation of your health condition in order for EDD to determine your eligibility for NDI benefits. While on NDI, health, dental, and vision benefits are covered.

Note: Employees in State Employees International Union (SEIU) bargaining units are not eligible for NDI, they are eligible for SDI instead.

State Disability Insurance (SDI): SDI pays part of an employee's wages if they have to stop working because of a non-work-related illness or injury. SDI also covers an employee if they take time off due to pregnancy or childbirth, or to bond with a minor child within one year of its birth, adoption, or foster care placement. SDI also covers time off to care for a seriously ill child, spouse, parent, or domestic partner.
You may be eligible to receive SDI benefits while waiting for an approval for your worker's compensation claim. If your claim is approved, any SDI benefits received may be required to be repaid.

SDI is an employee paid benefit and payments are administered by Employment Development Department (EDD). While on SDI, health, dental, and vision benefits are covered for up to 26 weeks.

Temporary Total Disability/Industrial Disability Leave/Labor Code 4800 Time: If you have an accepted workers' compensation claim, you may be entitled to Temporary Total Disability, Industrial Disability Leave, or Labor Code 4800/4800.5 benefits. Health care benefits are continued while receiving these benefits. To determine your eligibility, please contact your Return to Work Coordinator, the State Compensation Insurance Fund adjuster assigned to your claim, or your Workers' Compensation attorney.

3. *Separation from State Service*

Disability Retirement: If you are unable to return to work due to your health condition, you may apply for disability retirement with CalPERS. Disability retirement is considered a temporary separation from state service. Health benefits are available through CalPERS while you are on retirement status. If, after you are approved for disability retirement and, at a later date, it is determined that you are able to return to work as a [JOB TITLE], you will have mandatory rights to reinstatement to [JOB TITLE].

While you await the determination of your disability retirement application from CalPERS, you may use your existing leave credits, request FMLA/CFRA leave, or request a medical leave of absence. If you are eligible you may also apply for service retirement pending approval of your disability retirement.

Service Retirement: If you are eligible, you may apply for service retirement with CalPERS. A service retirement is a permanent separation from state service. Health benefits are available through CalPERS while you are on retirement. You would retain permissive reinstatement rights to state service.

Voluntary Resignation: You may choose to voluntarily resign from state service. You will retain permissive reinstatement rights. You may be able to purchase health, dental and vision benefits.

These options may not include all available legal options. If you have any other options that you would like to discuss, please let me know. If you do not respond to this letter or we are unable to reach a resolution, we may pursue one of the following options:

1. **Medical Transfer/Demotion:** If you are able to work in an alternate classification, we may medically transfer or demote you to a currently vacant position for which you meet the minimum qualifications.
   We will make an effort to place you in the highest paying vacant position for which you are qualified, which is not promotional and which meets your medical restrictions.

2. **Disability Retirement:** If you have not pursued disability retirement but are eligible to apply, we may file on your behalf. While the application is pending, you may utilize your existing leave credits until exhausted. If you exhaust all of your leave credits prior to CalPERS determination, you will be paid by the Department a temporary disability allowance (TDA) equal to the estimated amount of your disability retirement benefit. Should CalPERS grant the disability retirement application, you would then receive the disability retirement allotment directly from CalPERS. If the disability retirement application is denied, you have a right to return to work, with back pay, less any TDA received.

3. **Medical Termination:** If you are not entitled to disability retirement or you waive your right to file for disability retirement, we may medically terminate you pursuant to Government Code section 19253.5.

You must remain in contact with your supervisor in regard to any absence from work. Failure to report may result in the department invoking the Absence without Leave (AWOL) provisions of Government Code Section 19996.2. Absence without leave, whether voluntary or involuntary, for five consecutive working days is an automatic resignation from state service, as of the last date on which the employee worked.

We have attached an interest sheet for you to indicate which options you would like to discuss when we meet. Please fill it out and return it to me prior to our meeting so that I can be prepared to discuss those particular issues with you. You may indicate all options that you are interested in.

If we do not hear from you by [DATE], the department may pursue the options, as outlined above, without your input.

Sincerely,

Name
Title
Address
Phone number

Cc:

OPTION DISCUSSION INTEREST LIST

NAME:

The following is a list of possible options. Please indicate which ones you would like to discuss.

Return to work, with or without a reasonable accommodation

Medical transfer/demotion to another classification

Family Medical Leave/California Family Leave

Pregnancy Disability Leave

Medical Leave of Absence

Use existing leave balances

Temporary reassignment

Non-industrial Disability leave (NDI) or State Disability Insurance (SDI)

Temporary Disability/Industrial Disability Leave (IDL)/4800/4800.5 Time

Disability Retirement

Service Retirement

Voluntary resignation

The following dates are available for a meeting. Please indicate any that would be convenient for you.

(DATE) (DATE) (DATE) (DATE)

Please return in the enclosed stamped envelope as soon as possible.

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safetyofficerattorneys.com ★ www.law1199.com ★SCOTT A. O'MARA, THOMAS I. HAMPTON
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PENALTIES PLACED ON THE INSURER, SELF-INSURED EMPLOYER, THIRD-PARTY PARTY ADMINISTRATOR THROUGH FAILURE TO ADHERE TO LAW AND REGULATIONS OF WORKERS' COMPENSATION

BY: SCOTT A. O'MARA

Labor Code §129.5 states that there are administrative penalties and civil penalties that can be placed against an insurer, self-insured employer or third-party administrator for failure to comply with payment of mandated benefits and provision of medical care when the defendant has knowledge of the injured worker's entitlement to benefits and has not provided the same.

The code specifically states that if there is a failure to provide indemnity payments to the injured worker and/or failure to pay reasonable medical costs when benefits are undisputed, a penalty can be imposed. Additional penalties can be placed if there are failures to provide payments in the entire amount due for non-disputed permanent disability benefits, non-disputed death benefits and other benefits, in addition to penalties pursuant to Labor Code §5814. The Administrative Director (AD) of the Division of Workers' Compensation (DWC) can perform audits, whether done by random selection or based on complaints filed with the State. The AD can audit all aspects of how claims have been handled by the defendants: proper payment of permanent disability, temporary disability, death benefits, medical care, including whether payments have been made in correct amounts, paid timely. Labor Code §129.5 empowers the Administrative Director under the audit and endorsement unit to determine violations and impose penalties.

Additionally, again per Labor Code §129.5, the AD can impose a civil penalty of up to $100,000.00 upon finding, after a hearing has been held, that a employer, insurer, or third-party administrator has, "knowingly" committed or performed with sufficient frequency so as to indicate a general business practice any of the following:

(1) Induced employees to accept less than compensation due, or made it necessary for employees to resort to proceedings against the employer to secure compensation.

(2) Refused to comply with known and legally indisputable compensation obligations.

(3) Discharged or administered compensation obligations in a dishonest manner.

(4) Discharged or administered compensation obligations in a manner as to cause injury to the public or those dealing with the employer or insurer.

The most recent study by the Audit & Enforcement Unit for the year 2024 found that the for the small number of employers, insurers and administrators who were audited, a total of 4,531 rule violations were found, and penalties of $1,347,527.00 were imposed against the various parties.

These violations that can be found by the Administrative Director are is in addition to other sanctions that can be imposed for failure to provide timely benefits through the workers' compensation court. There are remedies available on individual cases so that a workers' compensation judge can order a defendant to pay a penalty for delayed, incorrect, or wrongfully denied payments.

The penalties under Labor Code §129.5(b) are designed to place economic consequences on the defendants for their business practices at large, in an effort to ensure that these entities properly provide benefits, and to ensure that they do not try to force the employee to accept less than the compensation due to them. Especially regarding insurers and third-party administrators, if they fail to meet these standards, they will not only suffer financially, but may also suffer reputational harm that could affect their business opportunities in the future.

This economic umbrella of protection is to ensure that the employers, insurers and third-party administrators comply with basic reasonable standards. Failure to do so can result in a significant penalty of up to $100,000.00. This was done in a recent case, and there were other sanctions imposed based upon the audit that was performed. The checks and balances that are needed ensure fair and timely access to medical care and monetary benefits is assisted by the Labor Code §129 & §129.5. The additional level of oversight provided by enforcement of these regulations helps to ensure prompt and accurate payment of workers' compensation benefits to the injured worker and/or their family members. However, ongoing challenges remain that can interfere with the injured worker's right to get medical care to cure or relieve the effects of their injury. The complexity of the system that exists now empowers the employer at the expense of the employee to take very significant and tactical methods to delay or deny. The current system has some accountability by Labor Code §129.5, but we need more accountability to ensure medical care is available to cure or relieve the effects of the injury so that the worker can return back to employment opportunities.

♦♦

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NOTICE: *Making a false or fraudulent Workers' Compensation claim is a felony subject to up to 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.*

♦♦