Answers to frequently asked questions about workers' compensation for employees

In addition to the FAQs below, employees may call 1-800-736-7401 to hear recorded information on a variety of workers' compensation topics 24 hours a day.

Employees may call a local office of the state Division of Workers' Compensation (DWC) and speak to the Information and Assistance (I&A) Unit for help during regular business hours, or attend a free seminar for injured workers.

Fact sheets and guides on a variety of topics can be found on the I&A Unit's Web page.

Topics covered in this FAQ include:

The basics
About employer responsibilities
About medical care
Temporary disability benefits
Permanent disability benefits
Returning to work
About navigating the workers' comp system

About the basics:

Q. What is workers' compensation?

A. If you have a work-related injury or illness, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work, such as hurting your back in a fall, getting burned by a chemical that splashes on your skin or getting hurt in a car accident while making deliveries.

--or--

Repeated exposures at work, such as hurting your wrist from doing the same motion over and over or losing your hearing because of constant loud noise.

How can I avoid getting hurt on the job?

A. Employers in California are required to have an injury and illness prevention program. The program must include worker training, workplace inspections, and procedures for correcting unsafe conditions promptly. Learn about and participate in your employer's program and report unsafe conditions to your employer. If they don't respond, call Cal/OSHA, the state agency that enforces health and safety laws.

Q. What should I do if I have a job injury?

A. Report the injury to your employer by telling your supervisor right away. If your injury or illness developed over time, report it as soon as you learn or believe it was caused by your job.

Reporting promptly helps prevent problems and delays in receiving benefits, including medical care you may need. If your employer does not learn about your injury within 30 days and this prevents your employer from fully investigating the injury and how you were injured, you could lose your right to receive workers' compensation benefits.

Get emergency treatment if you need it. Your employer may tell you where to go for treatment. Tell the health care provider who treats you that your injury or illness is job-related.

Fill out a claim form and give it to your employer. Your employer must give or mail you a claim form within one working day after learning about your injury or illness. If your employer doesn't give you the claim form you can download it from the forms page of the DWC website.

Q. Do I need to fill out the claim form (DWC 1) my employer gave me?

A. Yes. Giving the completed form to your employer opens your workers' compensation case. It starts the process for finding all benefits you may qualify for under state law. Those benefits include, but are not limited to:

- A presumption that your injury or illness was caused by work if your claim is not accepted or denied within 90 days of giving the completed claim form to your employer
- Up to $10,000 in treatment under medical treatment guidelines while the claims administrator considers your claim
- An increase in your disability payments if they're late
- A way to resolve any disagreements between you and the claims administrator over whether your injury or illness happened on the job, the medical treatment you receive and whether you will receive permanent disability benefits.

Q. What benefits am I entitled to?

A. Workers' comp insurance provides five basic benefits:

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work
- **Temporary disability benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering
- **Permanent disability benefits:** Payments if you don't recover completely
- **Supplemental job displacement benefits (if your date of injury is in 2004 or later):** Vouchers to help pay for retraining or skill enhancement if you don't recover completely and don't return to work for your employer
- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness.

Attend a free seminar for injured workers at a local DWC office for a full explanation of workers' comp benefits, your rights and responsibilities.

Q. What resources are available to me?

A. Your local I&A officers are a great resource and their services are free. They are not there to act on your behalf as an attorney would, but they'll help you understand how to act on your own behalf. Attend a free seminar for injured workers at a local DWC district office for a full explanation of workers' comp benefits, your rights and responsibilities. You can also make an appointment with an I&A officer and speak to them privately at your convenience.

In addition, there is a lot of information on the I&A page of the DWC's website. Check out the fact sheets and guides for injured workers. The fact sheets provide answers to frequently asked questions about issues affecting your benefits. The guides will help you fill out forms you may need to get a problem with your claim resolved at the local DWC district office.

Q. How can I find out who provides workers' compensation coverage for my employer or another business in California?

A. In California all employers are required to either purchase a workers' compensation insurance policy from a licensed insurer authorized to write policies in California or become self insured. The DWC does not provide workers' compensation insurance for employers and does not maintain information about employers and their respective insurers. To find out which insurer provides workers' compensation insurance for a specific employer, visit the California Workers' Compensation Coverage website. The roster of self-insured employers can be found on the Self Insurance Plans Web page.

More information about workers' compensation can be found on the DWC's Web page for injured workers.

Q. I know that independent contractors aren't covered under workers' compensation. How do I know if I really am an independent contractor?

A. There is no set definition of this term. Labor law enforcement agencies and the courts look at several factors when deciding if someone is an employee or an independent contractor. Some employers misclassify employees as an independent contractor to avoid workers' compensation and other payroll responsibilities. Just because an employer says you are an independent contractor and doesn't need to cover you under a workers' compensation policy, doesn't make it true. A true independent contractor has control over how their work is done. You probably are not an independent contractor when the person paying you:

- Controls the details or manner of your work
- Has the right to terminate you
- Pays you an hourly wage or salary
- Makes deductions for unemployment or social security
- Supplies materials or tools

- Requires you to work specific days or hours.

Q. What happens to an injured worker's personal information that is requested on various DWC forms? Is it kept confidential?

A. The division uses this information solely to administer its duties in workers' compensation claims. For example, if an injured worker provides their Social Security number (in whole or in part), DWC will use it as an identifier to ensure that documents are matched to the correct workers' comp case. Unless authorized by law to do so, DWC cannot disclose the residence addresses of injured workers or their Social Security number.

Note that some case file information can be found by using the public information case search tool on the DWC's website.

Q. What personal information can be found in a public information search?

A. The search tool shows limited case data, such as an injured worker's name, case number, case status, court location, employer name, a description of events in the case, and associated dates. It may list the parts of the body that were injured, but it does not include medical records or any case documents. The information provided in this search tool relates solely to cases in DWC's adjudication unit and is intended to help move cases through the court system efficiently. Any person requesting access to this information is required to identify themselves, state the reason for making the request and is instructed not to disclose the information to any person who is not entitled.

Injured workers should be aware that, once an Application for Adjudication of Claim is filed, case file information, including case documents, may be disclosed under the California Public Records Act. Even in this circumstance, an injured worker's address and Social Security number are not revealed to the requestor by the DWC.

Find more information about basic facts on workers' compensation in the factsheet.

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About employer responsibilities:

Q. What are my employer's responsibilities under workers' compensation laws?

A. Before an injury or illness occurs, your employer must:

- Obtain workers' compensation insurance or qualify to become self-insured
- When hiring a new employee, provide a workers' compensation pamphlet explaining the employee's rights and responsibilities
- Post the workers' compensation poster in a place where all employees can see it.

After an injury or illness occurs, your employer must:

- Provide a workers' compensation claim form to you within one working day a work-related injury or illness is reported
- Return a completed copy of the claim form to you within one working day of receipt
- Forward the claim form, along with the employer's report of occupational injury or illness, to the claims administrator within one working day of receipt
- Within one day of receiving your claim, authorize up to $10,000 in appropriate medical treatment
- Provide transitional work (light duty) whenever appropriate
- If you are the victim of a crime that happened at work, the employer must give notice of workers' compensation eligibility within one working day of the crime.

Q. Can my employer take part of my check to pay for workers' compensation insurance?

A. No. Workers' compensation insurance is part of the cost of doing business. An employer cannot ask you to help pay for the insurance premium.

Q. Isn't there supposed to be a notice posted at my workplace?

A. Yes. Your employer must post the notice to employees poster in a conspicuous place at the work site. This poster provides you with information on workers' compensation coverage and where to get medical care for work injuries. Failure to post this notice is a misdemeanor that can result in a civil penalty of up to $7,000 per violation.

Q. What happens if my employer is uninsured and I'm hurt on the job?

A. Failing to have workers' compensation coverage is a criminal offense a misdemeanor punishable by either a fine of up to $10,000 or imprisonment in the county jail for up to one year, or both. Additionally, the state issues penalties of up to $100,000 against illegally uninsured employers.

If you have a work-related injury or illness and your employer is not insured, your employer is responsible for paying all bills related to your injury or illness. Contact the information & assistance officer at your local DWC district office for further information. Workers' compensation benefits are only the exclusive remedy for injuries suffered on the job when your employer is properly insured. If your employer is illegally uninsured and you have a work-related injury or illness, you can file a civil action against your employer in addition to filing a workers' compensation claim.

You may also file a claim for benefits with the state's Uninsured Employers' Benefit Trust Fund (UEBTF). See DWC fact sheet F and guides 16, 16A and 16B for more information on filing a claim with the UEBTF.

Q. What is the Uninsured Employers' Benefit Trust Fund?

A. The UEBTF is a special unit within the Division of Workers' Compensation that may pay benefits to injured workers who get hurt or ill while working for an illegally uninsured employer.

The UEBTF pursues reimbursement of expenditures from the responsible employer through all available avenues, including filing liens against their property.

Q. Where can I report an employer for not carrying workers' compensation insurance?

A. You may report an uninsured employer to the nearest office of the Division of Labor Standards Enforcement. The offices are also listed in the state government section of the white pages of your local telephone directory under industrial relations, labor standards enforcement.

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About medical care:

Q. What kind of medical care will I receive for my injury?

A. Doctors in California's workers' compensation system are required to provide evidence-based medical treatment. That means they must choose treatments scientifically proven to cure or relieve work-related injuries and illnesses. Those treatments are laid out in a set of guidelines that provide details on which treatments are effective for certain injuries, as well as how often the treatment should be given (frequency), the extent of the treatment (intensity), and for how long (duration), among other things.

To comply with the evidence-based medical treatment requirement, the state of California has adopted a medical treatment utilization schedule (MTUS). The MTUS includes specific body regions guidelines adopted from the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, plus guidelines for acupuncture, chronic pain and therapy after surgery. The DWC has a committee that continuously evaluates new medical evidence about treatments and incorporates that evidence into its guidelines.

Q. Do these guidelines apply if my case is already settled?

A. They may. Treatment guidelines are considered correct even in cases that settled before the guidelines were added to workers' compensation law in 2003. Your claims administrator may continue to pay for medical care you're accustomed to for your injury. If you have a question about whether you should still be receiving a certain kind of medical treatment and you can't work it out with your claims administrator, call your local information & assistance officer for guidance.

If your medical treatment has been denied you can request an expedited hearing before a workers' compensation administrative law judge to get the situation resolved. Contact the information & assistance officer at your local DWC district office for help.

Q. The claims administrator hasn't accepted or denied my claim yet, but I need medical care for my injury now. What can I do?

A. The claims administrator is required to authorize medical treatment within one working day after you file a claim form with your employer, even while your claim is being investigated. The total cost of the treatment provided while your claim is being investigated is limited to $10,000. If the claims administrator does not authorize treatment right away, speak with your supervisor, someone else in management or the claims administrator about the law requiring immediate medical treatment. Ask for treatment to be authorized now, while waiting for a decision on your claim.

Q. Are there limits on certain kinds of treatment?

A. Yes. If your date of injury is in 2004 or later, you are limited to a total of 24 chiropractic visits, 24 physical therapy visits, and 24 occupational therapy visits, unless the claims administrator authorizes additional visits or you have recently had surgery and need postsurgical physical medicine.

Q. How long can I continue to receive treatment?

A. For as long as it's medically necessary. However, some treatments are limited by law and the medical treatment you receive must be evidence-based.

The MTUS lays out treatments scientifically proven to cure or relieve work-related injuries and illnesses. It also deals with how often the treatment is given and for how long, among other things.

If the treatment your doctor wants to provide goes beyond what is recommended by the MTUS, your doctor must use other evidence to show the treatment is necessary and will be effective.

Additionally, your doctor's treatment plan may be reviewed by a third party hired by the claims administrator. This process is called utilization review (UR). All claims administrators are required by law to have a UR program. They use UR to decide whether or not to approve treatment recommended by your doctor.

Q. What is utilization review?

A. UR is the program claims administrators use to make sure the treatment you receive is medically necessary. All claims administrators are required by law to have a utilization review program. This program will be used to decide whether or not to approve medical treatment recommended by your doctor.

The state has rules about how UR must be conducted. If you believe the UR company reviewing your doctor's plan is not following those rules you can file a complaint with the DWC.

Find more information about utilization review in the factsheet.

Q. If my doctor's request for treatment is not approved, what can I do?

A. There are specific timelines you must meet or you will lose important rights. As of July 1, 2013, medical treatment disputes for all dates of injury will be resolved by physicians through the process of independent medical review (IMR). If UR denies or modifies a treating physician's request for medical treatment because the treatment is not medically necessary, you can ask for a review of that decision through IMR.

Along with the written determination letter that denied or modified your requested treatment, you will receive an unsigned but completed IMR form and addressed envelope. If you disagree with the decision, you must sign and send this form in the envelope to start the IMR process.

Please visit the IMR FAQ at http://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm for detailed information about the process itself, eligibility and deadlines, as well as a link to the IMR request form.

Q. What happens if I was treated and the claims administrator won't pay for it? Do I have to pay?

A. You most likely will not have to pay. This is a problem your doctor and the claims administrator need to work out.

Q. What is a medical provider network?

A. A medical provider network (MPN) is a group of health care providers set up by your employer's insurance company and approved by DWC's administrative director to treat workers injured on the job. Each MPN includes a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. If your employer is in an MPN your workers' compensation medical needs will be taken care of by doctors in the network unless you were eligible to predesignate your personal doctor and did so before your injury happened.

Q. What is a health care organization?

A. A health care organization (HCO) is an organization certified by the DWC to provide managed medical care to injured workers.

Q. What is a primary treating physician (PTP)?

A. Your primary treating physician (PTP) is the physician with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated physician or medical group. If a physician says you still need treatment after 30 days, you may be able to switch to the physician of your choice. Different rules apply if your employer is using an HCO or a medical provider network (MPN).

Q. What does predesignating a personal doctor involve?

A. This is a process you can use to tell your employer you want your personal physician to treat you for a work injury. You can predesignate your personal doctor of medicine (M.D.) or doctor of osteopathy (D.O.) only if the following conditions are met:

1. A written notice predesignating the employee's personal physician or medical group is given in writing to the employee's employer prior to the date of injury for which treatment is sought and the notice includes the physician's name and business address;
2. The employee has healthcare coverage for non-occupational injuries or illnesses on the date of injury in a plan, policy or fund; and
3. The employee's personal physician or medical group agrees to be predesignated prior to the dates of injury.

The DWC has a form for predesignating a personal physician on the forms page of its website.

Q. I would like to be treated by my personal chiropractor or acupuncturist. How does that work?

A. If your employer or your employer's insurer does not have a MPN, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. There is a form you can use called the notice of personal chiropractor or personal acupuncturist. After your claims administrator has initiated your treatment with another doctor during the first 30 day period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

If you were injured on or after Jan. 1, 2004, a chiropractor cannot be your treating physician after 24 chiropractic visits. Once you have received 24 chiropractic visits if you still require medical treatment, you will have to select a new physician who is not a chiropractor.

Q. Does the 24 visit cap on chiropractic visits apply to all cases?

A. No. The 24 visit cap does not apply to injuries that occurred before Jan. 1, 2004. Also, the cap does not apply if your employer authorizes additional visits in writing. Additionally, the cap does not apply to visits for certain postsurgical physical medicine and rehabilitation services.

Q. What if I disagree with the MPN doctor's treatment plan?

A. If you disagree with your MPN doctor about your treatment, you can change to another physician on the MPN list. You can also ask for a 2nd and 3rd opinion from different MPN doctors. If you still disagree, you can have an IMR to resolve the dispute. See the information on your MPN provided by your employer.

Q. What if I disagree with the MPN doctor's opinion regarding my ability to return to work, whether I'm permanently disabled, or if I need future medical treatment?

A. If you disagree with your MPN doctor on any issues other than diagnosis or treatment, you must request a qualified medical examiner (QME).

Q. What if the MPN doctor's request for treatment is denied by UR or the claims administrator?

A. Along with the written determination letter that denied or modified your requested treatment, you will receive an unsigned but completed IMR form and addressed envelope. If you disagree with the decision, you must sign and send this form in the envelope to start the IMR process.

Please visit the IMR FAQ at for detailed information about the process itself, eligibility and deadlines, as well as a link to the IMR request form.

Q. Who decides what type of work I can do while recovering?

A. Your treating doctor is responsible for explaining in a medical report:

- The kind of work you can and can't do while recovering
- The changes needed in your work schedule or assignments.

You, your treating doctor, your employer and your attorney (if you have one) should review your job description and discuss the changes needed in your job. For example, your employer might give you a reduced work schedule or have you spend less time on certain tasks.

If you disagree with your treating doctor, you must promptly write to the claims administrator about the disagreement or you may lose important rights.

Q. I don't have an attorney and I have a disagreement about what my doctor report says about my injury. What should I do?

A. You may request a medical evaluation with a physician called a qualified medical evaluator or QME:

- If your claim is delayed or denied and you need a medical evaluation to find out if the claim is payable
- To find out if you are permanently disabled in some way or if you'll need future medical treatment
- If you disagree with what your treating physician says about your injury, work restrictions, or TD status. However, a QME may not comment on a request for medical treatment. If your doctor’s treatment request is denied and you disagree with the UR decision, you may request an IMR

If you are represented, your attorney and the claims administrator may agree on a doctor to examine you. To receive a list of QMEs to choose from, complete the panel request form (QME 105) and mail it to the DWC Medical Unit. Ask your treating physician to help if you don't know what kind of doctor should look at your injury.

Within 20 working days of the request, the DWC Medical Unit will send a list (also called a panel) of three QMEs to you and the insurance company. QME lists are randomly selected and do not represent your employer or the insurance company.

You have 10 days from the date the list is printed and mailed to select a QME from the list, make an appointment and tell the insurance company which doctor you picked and the date of your appointment. If you don't do this within 10 days, the insurance company will have the right to pick the doctor you'll see and make the appointment.

Q. What if the claims administrator has sent me a QME panel request form?

A. You might need to see a QME if the insurance company disagrees with something in your claim. In that case, the insurance company will give you the form to request a QME. When this happens, you have 10 days to request a QME list by sending the form to the DWC Medical Unit. If you don't send the form within 10 days of receiving it, the insurance company will have the right to request the QME list and select the kind of doctor you'll see.

Within 20 working days of the request, the DWC Medical Unit will send a list (also called a panel) of three QMEs to you and the insurance company. QME lists are randomly selected and do not represent your employer or the insurance company.

You have 10 days from the date the list is printed and mailed to select a QME from the list, make an appointment and tell the insurance company which doctor you picked, and the date of your appointment. If you don't do this within 10 days, the insurance company will have the right to pick the doctor you'll see and make the appointment.

Q. What qualifications do QMEs have?

A. The DWC Medical Unit certifies QMEs in different medical specialties. A QME must be a physician licensed to practice in California. QMEs can be medical doctors, doctors of osteopathy, chiropractors, psychologists, dentists, optometrists, podiatrists or acupuncturists.

Q. What's the difference between a QME and an AME?

A. If you have an attorney, your attorney and the claims administrator may agree on a doctor without using the state system for getting a QME. The doctor they agree on is called an agreed medical evaluator (AME). If they cannot agree, they must ask for a QME panel list.

Q. I don't get the QME process. Why do I need to see a QME?

A. You and/or the claims administrator might disagree with what the treating doctor says. There could be other disagreements over medical issues in your claim. A doctor has to address those disagreements. You might disagree over:

- Whether or not your injury was caused by your work
- Whether or not you may need future treatment for your injury

- Whether or not you need to stay home from work to recover
- A permanent disability rating.

The QME (or AME if you're represented by an attorney) report will help determine what benefits you receive.

Q. Is there anything I can do if I disagree with what the QME says?

A. Yes, but you have a limited amount of time to decide if you agree with the QME's report or if you need more information. When you receive the report, read it right away and decide if you think it is accurate. If not, and you have an attorney, you should talk to him or her about your options.

If you don't have an attorney, and you believe there are factual errors in the QME's report, you can request factual correction of the report by making a request within 30 days of receipt of the report.

The claims administrator may also request factual correction of the report.

Upon receipt of a request for factual correction of the report, the QME is required to file a supplemental report with the DEU and state whether factual correction is necessary to ensure accuracy of the report and, if so, whether the factual corrections change the opinions of the QME stated in the comprehensive medical report.

More information may be obtained from the I&A officer at your local DWC district office.

If you are in a union, you may be able to see an ombudsperson or mediator under the terms of your collective bargaining agreement or labor-management agreement.

Find more information about QMEs and AMEs in the factsheet.

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About temporary disability benefits:

Q. What are temporary disability benefits?

A. Temporary disability (TD) benefits are payments you get if you lose wages because your injury prevents you from doing your usual job while recovering. See the DWC fact sheet on TD for more information.

Q. Are there different types of TD benefits?

A. There are two types of TD benefits. If you cannot work at all while recovering, you receive temporary total disability (TTD) benefits. If you can't work your full schedule while recovering, you receive temporary partial disability benefit (TPD) payments.

Q. How much will I receive in TD payments?

A. As a general rule, TD pays two-thirds of the gross (pre-tax) wages you lose while you are recovering from a job injury. However, you cannot receive more than the maximum weekly amount set by law. Your wages are figured out by using all forms of income you receive from work: wages, food, lodging, tips, commissions, overtime and bonuses. Wages can also include earnings from work you did at other jobs at the time you were injured. Give proof of these earnings to the claims administrator. The claims administrator will consider all forms of income when calculating your TD benefits. Please see the benefits chart for current benefit rates.

The minimum and maximum rates are adjusted annually.

Q. What about TTD payments for low-wage workers?

A. Any employee with earnings is entitled to TTD benefits. TTD payments will be paid at two-thirds the injured worker's wages at time of injury. There are minimum and maximum rates for these benefits. Please consult the benefits chart for current rates.

The minimum TTD will continue to be re-calculated each Jan. 1 based on changes to the statewide average weekly wage (SAWW).

Q. When does TD start and stop?

A. TD payments begin when your doctor says you can't do your usual work for more than three days or you get hospitalized overnight. Payments must be made every two weeks. Generally, TD stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to. If you were injured after Apr. 19, 2004, your TD payments won't last more than 104 weeks within a period of 2 years from the first payment for most injuries. If you were injured after Jan. 1, 2008, your TD payments won't last more than 104 weeks within a period of 5 years from the date of your injury. Payments for a few long-term injuries such as severe burns or chronic lung disease can go longer than 104 weeks. TD payments for these injuries can continue for up to 240 weeks of payment within a five-year period.

Q. Are TD benefits taxable?

A. No. You don't pay federal, state or local income tax on TD benefits. Also you don't pay Social Security, taxes, union dues or retirement fund contributions.

Q. Can my first temporary disability payment be delayed?

A. Sometimes. If the claims administrator can't determine whether your injury is covered by workers' compensation, he or she may delay your first TD payment while investigating. A delay is usually not longer than 90 days. If there is a delay, the claims administrator must send you a delay letter. It must explain why you won't receive payments, what additional information the

claim administrator needs and when a decision will be made. If there are further delays, the claims administrator must send you additional delay letters.

If the claims administrator doesn't send you a letter denying your claim within 90 days after you filed the claim form, your claim is considered accepted in most cases.

Q. Is the claims administrator required to pay a penalty for delays in temporary disability payments?

A. It depends. If you had filed the workers' compensation claim form at least 14 days before the payment was due and the claims administrator sends a payment late, he or she must pay you an additional 10 percent of the payment on a self-assessed basis.

Q. Why am I receiving so many letters?

A. The claims administrator must keep you up to date by sending letters that explain how payments were determined, why TD will be delayed, reasons for changing TD payment amounts and why the TD benefits are ending.

Q. My temporary disability payments stopped without explanation. What should I do?

A. Talk to your employer or claims administrator. If that doesn't help, contact your local DWC I&A officer.

Find more information on TD in the factsheet.

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About permanent disability benefits:

Q. What are permanent disability benefits?

A. Most workers fully recover from job injuries but some continue to have medical problems. Permanent disability (PD) is any lasting disability that results in a reduced earning capacity after maximum medical improvement is reached. If your injury or illness results in PD you are entitled to PD benefits, even if you are able to go back to work.

PD benefits are limited. If you lose income, PD benefits may not cover all the income lost. If you experience losses unrelated to your ability to work, PD benefits may not cover those losses. See the DWC fact sheet on PD for more information.

Q. How is PD identified?

A. A doctor determines if your injury or illness caused PD. After your doctor decides your injury or illness has stabilized and no change is likely, PD is evaluated. At that time, your condition has

become permanent and stationary (P&S). Your doctor might use the term maximal medical improvement (MMI) instead of P&S.

Once you are P&S or have reached MMI, your doctor will send a report to the claims administrator telling them you have PD. The doctor also determines if any of your disability was caused by something other than your work injury. For example, a previous injury or other condition. Assigning a percentage of your disability to factors other than your work injury is called apportionment.

Q. What happens to the doctor's report?

A. If you were evaluated by a QME, the QME's report is sent to the claims administrator and to the DWC's Disability Evaluation Unit (DEU). A rater from the DEU will use the QME's report and the Employee Disability Questionnaire that you filled out and gave to the QME at the time of your appointment to calculate your PD rating. If you have an attorney, the rating can be done by either the DEU or a private rater.

You or the claims administrator also has the right to have the report of your primary treating physician (PTP) rated, but this does not happen automatically. You must request a rating of the PTP's report by completing a Request for Summary Rating Determination of Primary Treating Physician's Report and sending it to the DEU with a copy of the PTP's report.

The process used to calculate your rating can vary, depending on your date of injury or other factors. The PD rating is used in a formula that determines the benefits you'll receive.

You have a right to receive a copy of the QME's report as well as the reports from your PTP. Read the QME's and PTP's reports carefully. Make sure they are complete and do not leave out important information. If you believe there are factual errors in the QME's comprehensive report, you can request a factual correction of the report, but you must do so within 30 day of receipt of the report.

The QME will review the request and will issue a supplemental report indicating whether factual correction is necessary to ensure accuracy of the report and how any changes affect the QME's opinions.

Q. What if I don't agree with the doctor?

A. If you or the claims administrator disagrees with your doctor's findings you can be seen by a doctor called a QME. You request a QME list (called a panel) from the DWC Medical Unit. The claims administrator will send you the forms to request a QME. Your employer will pay for the cost of the QME exam. You have 10 days from the date the claims administrator tells you to begin the QME process to submit your request form to the DWC Medical Unit. If you do not submit the form within 10 days, the claims administrator will do it for you and will get to choose the kind of doctor you'll see.

There are other specific and strict timelines you must meet in filing your QME forms or you will lose important rights. Read DWC Information and Assistance Unit guide 2 for more information.

When you receive the list of QMEs from the DWC Medical Unit you have to select a doctor, set up an exam and tell the claims administrator about your appointment. If you do not make the appointment within 10 days, the claims administrator may pick the doctor and make the appointment for you.

If you have an attorney, he or she can help you pick a QME or you can be evaluated by AME. An AME is the doctor your attorney and the claims administrator agree on to do your medical examination. In this case you should discuss your options with your attorney.

Q. Can I get more detail about the PD rating and how it is calculated?

A. After your examination the doctor will write a medical report about your impairment. Impairment means how your injury affects your ability to do normal life activities. The report includes whether any portion of your disability was caused by something other than your work injury. The doctor's report ends with an impairment number.

Next, the impairment number is put into a formula to calculate your percentage of disability. Disability means how the impairment affects your ability to work. Your occupation and age at the time of your injury and your future earning capacity are all also included in the calculation.

Then, any portion of your disability caused by something other than your work injury is taken out of the calculation.

Your disability will then be stated as a percentage. Your percentage of disability equals a specific dollar amount, depending on the date of your injury and your average weekly wages at the time of injury. A rating specialist from the DWC DEU Unit may help calculate your rating.

If you were injured between Jan. 1, 2005 and Dec. 31, 2012 your PD award may be increased or decreased by 15 percent, depending on whether you work for an employer with 50 or more employees and your employer offers regular, alternative or modified work.

Q. I don't agree with the rating by the state disability rater. What can I do?

A. If you don't have an attorney, you can ask the state DWC to review the rating. The DWC will determine if mistakes were made in the medical evaluation process or the rating process. This is called reconsideration of your rating. See I&A guide 3 for more information. You can also present your case to a workers' compensation administrative law judge. Contact a state I&A officer for help. Workers with attorneys cannot request reconsideration. If you have an attorney, he or she can present your case to a judge.

How much will I be paid for my permanent disability?

A. PD benefits are set by law. The claims administrator will determine how much to pay you based on three factors:

- Your disability rating (expressed as a percentage)
- Date of injury
- Your wages before you were injured.

Q. How and when are PD benefits paid?

A. PD benefits are normally paid when TD benefits end and your doctor indicates you have some permanent effects from your injury. The claims administrator must begin paying your PD payments within 14 days after TD ends. The claims administrator picks which day to pay you and will continue to make payments every two weeks until a reasonable estimate of your disability amount has been paid.

If you have not missed any work, PD payments are due when the claims administrator learns the injury has caused a permanent disability.

Q. Why am I receiving so many notice letters?

A. By law, the claims administrator must keep you up to date by sending letters that explain how PD payment amounts were determined, when you will receive PD payments, why PD payments will be delayed and why PD benefits won't be paid.

Q. Is the claims administrator required to pay a penalty for delays in PD payments?

A. Yes. If the claims administrator sends a payment late, he or she must pay you an additional 10 percent on a self-assessed basis. This is true even if there was a reasonable excuse for the delay and even if the claims administrator sends a letter explaining the delay. You could be awarded a substantial extra payment if there was no reasonable excuse for the delay.

Q. How is my claim finally resolved?

A. After the amount of PD in a claim is determined, there is usually a settlement or award for benefits. This award must be approved by a workers' compensation administrative law judge. If you have an attorney, your attorney should help you obtain this award. If you don't have an attorney, the claims administrator should help you obtain the award. You can also get help from the I&A officer at the local DWC district office. If your doctor said further medical treatment for your injury or illness might be necessary, the award may provide future medical care.

You can resolve your whole claim through one lump sum settlement called a C&R . A C&R may be best when you want to control your own medical care and/or you want a lump sum payment for your permanent disability. A C&R usually means that after you get the lump sum payment approved by the workers' compensation judge, the claims administrator will not be liable for any further payments or medical care.

You can also agree to a settlement called a stip or stipulation. A stip usually includes a sum of money and future medical treatment. Payments take place over time. A judge will review the agreement.

If you cannot agree to a settlement with the claims administrator, you can go before a workers' compensation administrative law judge, who will decide your permanent disability award. A judge's finding is called a F&A. The F&A generally consists of a sum of money and a provision for the claims administrator to pay for approved future medical treatment.

If you agree to a stip or receive an F&A, the amount of your PD benefit will be spread over a fixed number of weeks. If you C&R your case you get a lump sum payment. If you have PTD, you are eligible to receive payments for the rest of your life.

In all of these situations your PD payments will likely begin before the final decision about the amount of your PD is reached. That's because, once your doctor says you have permanent disability, the claims administrator will estimate how much you should receive and begin making payments to you before the final percentage of disability has been calculated.

When the actual amount of PD due has been determined, the amount due over the original estimate will be paid.

Find more information about permanent disability in the factsheet.

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About returning to work:

Q. I really just want to get back to work. How can I make that happen?

A. Injured workers who return to the job as soon as medically possible have the best outcomes. They recover from their injuries faster and suffer less wage loss. Your decision about returning to work will be influenced by your doctor, your employer and the claims administrator. Communicate honestly and frequently with them for the best results.

If your doctor decides you cannot return to work while recovering from your injuries you cannot be required to go back to your job.

Sometimes you can go back to your job with work restrictions if your employer is willing and able to make accommodations. For example, your employer may change certain parts of your job or provide you with new equipment.

If your doctor says you can go back to work with restrictions but your employer is unwilling or unable to accommodate your injuries, you are not required to return to work.

Meanwhile, depending on your injuries, you may be eligible for TD, supplemental job displacement benefits or PD benefits.

Q. How is my ability to return to work determined?

A. Returning to work safely and promptly can help in your recovery. It can also help you avoid financial

losses from being off work. After you are hurt on the job, several people will work with you to decide when you will return to work and what work you will do. These people include:

- Your treating doctor
- Managers who represent your employer
- The claims administrator handling your claim for your employer.

Sometimes doctors and claims administrators do not fully understand your job or other jobs that could be assigned to you. That's why it is important that everyone stay in close contact throughout the process. You (and your attorney if you have one) should actively communicate with your treating doctor, your employer and the claims administrator about:

- The work you did before you were injured
- Your medical condition and the kinds of work you can do now
- The kinds of work your employer could make available to you.

Q. Can I work while I am recovering?

A. Soon after your injury, the treating doctor examines you and sends a report to the claims administrator about your medical condition. If the treating doctor says you are able to work, he or she should describe:

- Clear and specific limits, if any, on your job tasks while recovering. These are called work restrictions. They are intended to protect you from further injury (example: no work that requires repetitive bending or stooping)
- Changes needed, if any, in your schedule, assignments, equipment or other working conditions while recovering (example: provide headset to avoid awkward positions of the head and neck)
- If the treating doctor reports that you cannot work at all while recovering you cannot be required to work.

Q. I have work restrictions. Can I work?

A. If your treating doctor reports that you can return to work under specific work restrictions, any work your employer assigns must meet these restrictions. Your employer might, for example, change certain tasks or provide helpful equipment. Or your employer may say that work like this is not available. If so, you cannot be required to work.

Q. What if I have no work restrictions?

A. If your treating doctor reports that you can return to your job without restrictions, your employer usually must give you the same job and pay you had before you were injured. The employer can require you to take the job. This could happen soon after the injury, or it could happen much later, after your condition has improved.

Q. What if my employer offers me work?

A. If the claims administrator's letter says your employer is offering you work, the job must meet the work restrictions in the doctor's report. The offer could involve:

- **Regular work:** Your old job, for a period of at least 12 months, paying the same wages and benefits as paid at the time of an injury and located within a reasonable commuting distance of where you lived at the time of your injury
- **Modified work:** Your old job, with some changes that allow you do to it. If your doctor says you will not be able to return to the job you had at the time of injury, your employer is encouraged to offer you modified work instead of supplemental job displacement benefits (SJDB). The alternative work must meet your work restrictions, last at least 12 months, pay at least 85 percent of the wages and benefits you were paid at the time you were injured and be within a reasonable commuting distance of where you lived at the time of injury
- **Alternative work:** A new job with your employer. If your doctor says you will not be able to return to the job you had at the time of injury, your employer is encouraged to offer you alternative work instead of SJDB. The alternative work must meet your work restrictions, last at least 12 months, pay at least 85 percent of the wages and benefits you were paid at the time you were injured, and be within a reasonable commuting distance of where you lived at the time of injury.

If your employer offers you modified or alternative work:

- You may have only 30 days to accept the offer. If you don't respond within 30 days, your employer could withdraw the offer
- If you fail to respond to the offer of modified or alternative work within 30 days or reject the job offer, you will probably not be entitled to supplemental job displacement benefits.

Q. What if my employer does not offer me work?

A. If you were injured between Jan. 1, 2004 and Dec. 31, 2012, and your employer has 50 or more workers, and you are not offered regular, modified or alternative work, your weekly PD benefits will be increased by 15 percent once that offer is made.

If you were injured between Jan. 1, 2004 and Dec. 31, 2012, and your employer has fewer than 50 workers, and you are not offered regular, modified or alternative work, your PD benefits will not change.

If you were injured on or after Jan. 1, 2013, your permanent disability benefits will not change if you are not offered regular, modified or alternative work, regardless of the size of the employer.

Q. Why are my PD disability benefits affected by the return to work offer?

A. The state's experience and extensive studies have shown that the longer you stay off work the less likely you are to go back, and that leads to more wage loss and a lower quality of life. PD benefits will never make up for the money you lose by not returning to work, so these provisions were put in place to get you back to your job as soon as medically possible.

Of course, for some people this just may not be possible. Consult an I&A officer or an advocate of your choice if your situation is complex or you need to figure out what other resources are available to you.

Q. What if the job my employer offered does not work out?

A. Depending on your date of injury, you may still be entitled SJDB if the job does not last for 12 months or your disability prevents you from performing the tasks involved in the job. If you have concerns, talk to your employer or the claims administrator. If that doesn't help, call a state I&A officer.

Q. How do I qualify for SJDB?

A. If you were injured on or after Jan. 1, 2004, and are permanently unable to do your usual job, and your employer does not offer other work, you may qualify for SJDB. This benefit is in the form of a voucher that helps pay for educational retraining or skill enhancement -- or both -- at state-approved or state-accredited schools.

For date of injury on or after Jan. 1, 2004 and prior to Jan. 1, 2013, employees who do not return to work for their employer within 20 calendar days from the expiration of time for making an offer of regular, modified, or alternative work will receive a voucher. The amount of the voucher is based on the percentage of disability:

- Up to $4,000 voucher for permanent partial disability of less than 15 percent
- Up to $6,000 voucher for permanent partial disability between 15 and 25 percent
- Up to $8,000 voucher for permanent partial disability between 26 and 49 percent
- Up to $10,000 voucher for permanent partial disability between 50 and 99 percent

Up to 10 percent of the voucher funds may be used for vocational or return-to-work counseling.

The law also says that an employer will not be liable for providing the SJDB to an employee if, within 30 days of the end of TD payments, an offer of modified or alternative work is made, and the employee rejects or fails to accept the offer in the form and manner prescribed by the DWC administrative director.

For injuries occurring on or after Jan. 1, 2013, the voucher amount is $6,000.00 regardless of the PD rating. The voucher will be due within 20 calendar days from the expiration of time for making an offer of regular, modified, or alternative work. The job must pay no less than 85% of the employee's earnings at the time of injury and must be expected to last at least 12 months.

Q. What if my employer offers a modified or alternative job and I don't accept it? Can I still receive the voucher?

A. No. For injuries occurring between Jan. 1, 2004 and Dec. 31, 2012, if the employer sends a notice of offer of modified or alternative work within 30 days of your last temporary disability (TD) payment and the offer meets certain requirements, and you don't accept the job, you're not eligible for the voucher. The offer of modified or alternative work must meet the following conditions:

- You have the ability to perform the essential functions of the job
- The job is a regular position lasting at least 12 months
- The job offers wages and compensation that are at least 85 percent of those paid to you at the time of your injury
- The job is located within reasonable commuting distance of your residence at the time of injury.

For injuries on or after Jan. 1, 2013, if the employer makes an offer of regular, modified, or alternative work within 60 days after receipt by the claims administrator of the Physician's Return-to-Work & Voucher Report and the offer meets certain requirements and you don't accept the job, you're not eligible for the voucher. The offer of modified or alternative work must meet the following conditions:

- You have the ability to perform the essential functions of the job
- The job is a regular position lasting at least 12 months
- The job offers wages and compensation that are at least 85 percent of those paid to you at the time of your injury
- The job is located within reasonable commuting distance of your residence at the time of injury.

Job offers should not be filed with DWC.

Q. When will I receive the SJDB voucher?

A. For injuries occurring between Jan. 1, 2004 and Dec. 31, 2012, if you are eligible for the voucher and you haven't settled your eligibility (as part of an overall settlement in your case) you will receive the voucher from the claims administrator within 25 calendar days from the date your disability award is issued by the workers' compensation judge at the local Workers' Compensation Appeals Board district office. For injuries occurring on or after Jan. 1, 2013, the voucher is due 60 days after a treating doctor, AME or QME declares the injured worker permanent and stationary, and issues a report outlining the worker's work capacities, if the employer does not offer the worker a job.

Q: When can I expect to receive the payments specified in the voucher?

A. The claims administrator must issue reimbursement payments to you or direct payments to the VRTWC and training provider within 45 calendar days from receipt of the completed voucher, receipts and documentation.

Q. I disagree with my treating doctor's opinion about the work I can handle. What can I do?

A. Different doctors may have different opinions about a worker's ability to do tasks safely. You have a right to question or disagree with a report written by your treating doctor. To dispute the doctor's report about your ability to work:

- If you do not have an attorney, you must send a letter to the claims administrator stating that you disagree with the report. You must send the letter within 30 days of receiving the report
- If you have an attorney, contact your attorney right away. The deadline for stating your disagreement is 20 days
- Next, you can get a medical evaluation from another doctor. For information about medical evaluations, call the DWC Medical Unit at 1-800-794-6900.

For help in getting a medical evaluation, contact a DWC I&A officer.

Q. I don't agree with my employer about work assigned or offered to me. What can I do?

A. If your employer assigns or offers you work that does not meet the work restrictions required by your treating doctor, you don't have to accept it. Contact a DWC I&A officer for more details on how to proceed.

It is illegal for an employer to discriminate against you because you requested workers' compensation benefits or because you have a work-related disability. This is prohibited by California Labor Code section 132a, the federal Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA).

However, an employer is not always required to offer you a job or offer a job that you may want. For example, there may not be any jobs you can do that meet the doctor's work restrictions.

Q. What if I don't have any PD (a zero rating) but I still can't return to work?

A. There is nothing more the DWC can do for you at that point, but other types of assistance may be available:

- State disability insurance (SDI) or, in rare cases, unemployment insurance (UI) benefits paid by the state Employment Development Department (EDD)
- Social Security disability benefits paid by the U.S. government for total disability
- Benefits offered by employers and unions, such as sick leave, group health insurance, long term disability insurance (LTD) and salary continuation plans
- A claim or lawsuit if your injury was caused by someone other than your employer.

You should also be aware that the federal Americans with Disabilities Act (ADA) prohibits discriminating against those with physical or mental impairments that substantially limit one or more life activities, and who can perform essential job functions. An employer is required to provide a reasonable accommodation if it would not impose an "undue hardship" on them.

For information on the ADA, call the Equal Employment Opportunity Commission at 1-800-USA-EEOC.

Additionally, the state Department of Fair Employment and Housing administers the California Fair Employment and Housing Act (FEHA), which prohibits harassment or discrimination in employment, housing and public accommodations. For more information on FEHA call 1-800-884-1684.

Q. Can the voucher be settled for a cash payment?

A. Not for injuries on or after Jan. 1, 2013.

Q. **Does a voucher expire?**

A. The voucher does not expire if issued prior to Jan. 1, 2013. If issued on or after Jan. 1, 2013, the voucher will expire within two years of being issued or five years from the date of injury, whichever comes later.

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About navigating the workers' comp system:

Q. The workers' comp system seems very confusing. Should I get an attorney?

A. That's a question you have to answer for yourself. The vast majority of workers' compensation claims are resolved between injured workers and claims administrators with no problems. You're not required to have an attorney, even if you have a disagreement with the claims administrator. However, if your case is complex you may benefit from having one. Your attorney can't directly charge you for his or her services. Your attorney's fee will be paid out of a portion of your workers' compensation benefits. If you decide not to get an attorney, the I&A officer at your local DWC district office can help you with your claim. Even if you decide to hire an attorney you should educate yourself about your rights and responsibilities, stay in communication with your employer and claims administrator and don't be afraid to ask them questions.

Q. I'm having a problem getting my benefits. What resources are available to me?

A. Your local I&A officers are a great resource and their services are free. They are not there to act on your behalf as an attorney would, but they'll help you understand how to act on your own behalf. Attend a free seminar for injured workers at a local DWC district office for a full explanation of workers' comp benefits, your rights and responsibilities. You can also make an appointment with an I&A officer and speak to them privately at your convenience.

You can also find a lot of information on the I&A page of the DWC's website. Check out the fact sheets and guides for injured workers. The fact sheets provide answers to frequently asked questions about issues affecting your benefits. The guides will help you fill out forms you may need to get a problem with your claim resolved at the local DWC district office.

Q. I'm disabled and need assistance in order to use DWC services. Is there any help available?

A. Yes. If you have a disability and are using the services of the Division of Workers' Compensation you may be eligible for a reasonable accommodation. A reasonable accommodation is assistance given to disabled individuals to promote equal access to and participation in our programs and services. Those services include the Worker's Compensation Appeals Board, the Information and Assistance Unit, the Retraining and Return to Work Unit and the Disability Evaluation Unit. You can find out more about reasonable accommodation, including how to request one, at the disability accommodation page.

For more information on receiving an Americans with Disabilities Act (ADA) accommodation.

Q. Besides workers' compensation benefits, can I get any other financial assistance?

A. Other benefits may be available. These include:

- Benefits paid by the state and federal governments such as State Disability Insurance (SDI), unemployment insurance, and Social Security Disability Insurance (SSDI) payments
- Benefits offered by employers and unions, such as sick leave, group health insurance, long term disability (LTD) and salary continuation plans
- Payments if your injury was caused by someone other than your employer.

Q. How do I find out what's going on with my case?

A. If you have an attorney, he or she should be keeping you up to date. If you don't have an attorney, contact the I&A officer at your local DWC district office for a status report. The DWC also has a call center through which many calls to local offices are routed. The call center staff is also fully equipped to give you status updates on your case.

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