



# What you don't know about workers' comp can hurt you

## A look at the pitfalls for an unrepresented claimant in the WC system

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The workers' compensation system gives the illusion that it is accessible to all and designed to take care of the injured worker even if they do not have an attorney. Do not be allow your clients to be deceived. The claims adjuster, defense attorney and the employer's insurance company are not always there to help the injured worker and are in fact trained and incentivized to take advantage of those who are unrepresented. From the beginning, every workers' compensation claim has pitfalls for the unaware claimant:

1. The initial claim-reporting and investigation process to determine whether, and to what extent, a claim is compensable;
2. The determination of who your treating doctor will be;
3. What treatment will be approved (even if recommended by your treating doctor); and,
4. Who will provide a medical-legal assessment and determine your disability and entitlement to benefits including future medical care.

The purpose of this article is to advise plaintiffs' attorneys whose clients have ancillary workers' compensation claims of the hazards and pitfalls that are pervasive within the workers' compensation system. It will provide some warnings and guidance on successfully navigating the system and maximizing the benefits delivered.

### An adversarial system

In theory, the workers' compensation system is designed with the intent to efficiently and expeditiously provide limited benefits to injured workers in exchange for limited liability by the employer. In practice, for many the system is adversarial from the inception of a claim, with rapid deadlines and conflicting duties that cause confusion and consternation to even seasoned practitioners. Comfortably navigating the system takes years of practice and education, yet for the majority of injured workers in California there is only one party who has the requisite expertise to muddle through the process, and they work for employers and insurance carriers to further their interests. For a decade, we, the authors, counted ourselves among them.



### Claim reporting and investigation issues

At the outset it is important to briefly discuss what, in fact, qualifies as an injury for purposes of workers' compensation law. Labor Code section 3208 provides limited assistance in this regard, noting that an injury "includes any injury or disease arising out of the employment." In general, an injury will be either specific and distinct or cumulative in nature under Labor Code section 3208.1. In order to be compensable, it will generally require some medical treatment beyond first aid or the loss of time from work beyond the employee's scheduled shift. (Lab. Code, § 5401, subd. (b); see also *Livitsanos v. Superior Court* (1992) 2 Cal.4th 744.)

"Within one working day of receiving notice or knowledge of injury... which results in lost time beyond the employee's work shift at the time of injury, or which results in medical treatment beyond first aid, the employer shall provide, personally or by first class mail, a claim form and a notice of potential eligibility for benefits..." (Lab. Code, § 5401, subd. (a).) The employee should complete and file the claim form with the employer,



either personally or by first class mail. (Lab. Code, § 5401, subd. (c).) Upon receipt of a claim form an employer must conduct a *good faith* investigation regarding a claim's compensability and make a determination within 90 days. (Lab. Code, § 5402.) Failure to timely accept or reject liability for a claim creates a presumption of compensability, and evidence obtained at a later date which may provide basis to deny a claim will be barred if it was available during the initial investigation period. (*Ibid.*)

### Workers don't initiate the claim

It is crucial to understand that when a claim is reported to an insurance carrier it is rarely done by the injured worker themselves, so the narrative will inherently be colored in light of the employer's concerns. This narrative will shape the course of a claim until corrected, resulting in claimants being denied the impartial investigation that the system is intended to provide. The employer, through their claims adjuster or insurance carrier, has many arrows in their quiver to assist in their investigation. They may take written or recorded statements from the claimant and their coworkers or supervisors, subpoena medical records, and require the claimant to submit to medical evaluations with physicians of their choosing. However, these tools are all too often focused on searching for reasons to deny or limit claims, rather than investigate them.

When dealing with clients who may be unrepresented on an ancillary workers' compensation claim, it is important to counsel them on the process. The claimant has the burden of providing information to the claims adjuster sufficient to substantiate their claim, be it in the form of medical evidence or factual statements or documentation.

It is equally important to reinforce that they need to provide information about the entire scope of their claim, including all body parts or conditions that may be at issue, regardless of severity. A fall resulting in a knee injury may also

involve trauma to the arm that braced the fall, or any other body part that impacted the ground, yet a savvy claims administrator may provide the unrepresented claimant with a claim form listing only the knee. Medical treatment authorizations and medical-legal determinations would be directed only to one part of the claim, which if allowed to continue, will create the false appearance that a claimant is "adding" body parts later in the claim. This may trigger subsequent medical-legal evaluators and judges to wrongly question the claimant's credibility when the truth of the matter is the claims adjuster has manufactured the entire situation. Therefore, it is imperative to instruct unrepresented claimants to be direct, forceful, and complete regarding the reporting of their claim in the early stages and advise the required parties when new issues arise.

### Medical control: Who can treat?

An injured employee will be bombarded with notices in the early phases of their claim. These notices, intentionally or not, all share a very similar appearance and contain duplicate enclosures that tend to lull an inexperienced claimant into a false sense of routine and security. Buried in these notices are standard notices pursuant to *Reynolds v. Workmen's Comp. Appeals Bd.* (1974) 12 Cal.3d 726, advising the employee of their legal rights and remedies in the event of the denial of all or part of their claim, as well as general potential benefit eligibility and legal rights found in Title 8 CA Code of Regulations § 10139. (For an example of the standard notices, refer to <https://www.dir.ca.gov/dwc/DWCForm1.pdf>)

Other benefit notices will include mandatory language referring a claimant to their attorney if they have one, or the claims adjuster if they do not, for any questions or objections they may have. (Title 8 California Code of Regulations § 9810(e). Contained within all of these boilerplate notices are important legal rights that few claimants are actually aware of.

Regarding medical treatment, defendants generally have absolute control of the first 30 days of medical treatment, allowing them to send an injured employee to a physician of their choosing to provide an initial opinion on compensability of a claim. (Lab. Code, § 4600, subd. (c).) The employer is sending claimants to doctors of their choosing, who know all too well that they are being chosen to issue opinions that the claims administrator is seeking. After 30 days, unless the employer has a valid Medical Provider Network (MPN), the employee is free to select a physician of their choosing; however, often, this ability is hidden or unknown. Why would a claimant not exercise control over their medical care after the initial 30 days?

Exercising control can come in two forms. Prior to an injury, an employee has the option to pre-designate a treating physician pursuant to Labor Code section 4600, subdivision (d). The designated physician must be the employee's regular primary care physician, licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code, who maintains the employee's medical records and agrees to be pre-designated. (Lab. Code, § 4600, subd. (d)(2).) The designated physician need not be someone that the injured employee has ongoing and regular treatment appointments with, but they must be the actual primary care physician to justify the pre-designation. (See *Maia v. Redneck Trailer Supply* 2017 Cal. Wrk. Comp. P.D. Lexis 582.)

After an injury, unless the employer has an MPN, the claimant can choose any doctor to treat them that they wish. If an MPN is present, it can be challenged on numerous grounds. Labor Code section 4616, subdivision (a)(1) requires that "[t]he provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged ..." Title 8 CA Code



of Regulations section 9767.5(a)(1) requires that an MPN must have at least three available primary treating physicians and a hospital for emergency health, or a provider of emergency health services, within 30 minutes or 15 miles of each employee's residence or workplace. The MPN must have specialists available to treat common injuries sustained by injured employees within 60 minutes or 30 miles of each employee's residence or workplace. Failure to meet these thresholds can preclude a defendant from mandating treatment within their MPN and allow an injured employee to seek treatment with a physician of their choosing.

### Claimants should exercise their rights

Too many unrepresented claimants unknowingly fail to exercise their right to control their own medical care after the first 30 days of a claim and continue to seek medical treatment and benefits as endorsed by doctors who are incentivized by insurance companies to reduce the cost of claims. On many occasions, defendants will remove doctors from their networks who fail to limit the scope of treatment or provide "excessive" disability in the eyes of an insurance company's claims adjuster. Challenging a defendant's MPN for having a lack of available doctors can effectively wrest control from them and return it to the claimant. Additionally, in many circumstances, delays in authorizing doctors for treatment or referrals can become a basis to set aside the defendant's control of medical care. Sometimes a simple demand letter can free a claimant from the defendant's restrictions; however, often, legal intervention through the WCAB is required. The workers' compensation system exists to provide medical care to cure or relieve a claimant from the effects of their industrial injury and prevent them from destitution while they are recovering. Therefore, a claimant who wished to maximize their medical and benefit recovery must be advised of, and assisted in, securing their

legal right to challenge a defendant's ability to mandate unfair medical treatment in their claim.

### Medical control: What can be treated?

Those experienced with the workers' compensation system know that, in spite of the stated intent that the system should provide expedited medical treatment to injured workers, in practice, the process of obtaining medical care is often frustrating and requires litigation to properly effectuate. This is due to numerous statutory revisions over the past two decades that have created roadblocks to medical care by substituting the opinion of a physician employed, or paid for, by the defendants in place of that of the actual physician with a relationship to the claimant. California Senate Bill 228, passed in 2003, created the Utilization Review scheme that controls medical treatment determinations in the workers' compensation system. In 2004, California Senate Bill 899 made the process mandatory, followed by the 2012 California Senate Bill 863 which significantly limited the utilization review appellate process.

Utilization Review is defined in Labor Code section 4610, subdivision (a) as a system that "functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians..." The laws regarding the timeframes for a utilization review decision are many, but primarily found in Labor Code section 4610, subdivision (i) and Code of Regulations section 9792.9.1. In general, a decision must be made within five "working" days for any prospective requests for treatment, 30 days for retrospective requests for treatment, and within 72 hours for emergency or expedited requests. Numerous cases, statutes and regulations have parsed out what constitutes a working day, when one day ends and another begins for timing

purposes, what content must be contained in a decision, and who must receive the determinations for them to be valid. If a decision is timely, the decision is valid for one year unless successfully challenged, and the WCAB generally does not have jurisdiction to hear challenges to disputes as to the substance of the analysis. (See Lab. Code, §§ 4604, 4610, subd. (k); *Dubon v. World Restoration, Inc.* (2014) 79 CCC 1298 (appeals board *en banc*.) The only recourse to an adverse utilization review determination is an appeal to Independent Medical Review within 30 days pursuant to Labor Code section 4610.5, subdivision (h)(1). Unfortunately, the results are generally the same with IMR, who had a 91.1% uphold rate for decisions denying treatment in 2022. ([https://www.cwci.org/press\\_release.html?id=954](https://www.cwci.org/press_release.html?id=954) (as of 8/1/2023).)

Many seasoned workers' compensation practitioners find it difficult to navigate the precise timelines and challenges of the UR and IMR systems, so it would be a rare case for an unrepresented claimant to successfully challenge denial of medical treatment in light of the fact that a WCAB judge often lacks jurisdiction to help them. The only consistent way to reestablish jurisdiction is to identify a technical violation of the process. However, the laws in this area are complex and nuanced and require expertise to enforce. There exist potential avenues to challenge adverse decisions based on the timing of the decision, the form and sufficiency of the communication of the decision, and the compliance on the part of claims administrators relating to the information and documentation provided to UR and IMR. Failure to pursue these challenges carries with it a high cost in the form of a yearlong denial of care, which handcuffs the claimant and their physician absent a change of circumstances. (See *Wyant v. American Medical Response* (2017) 83 CCC 946.)

Although every UR and IMR decision presents the defendants with costs and expenses related to the process,



ultimately it is viewed as a cost-saving measure. Often, unrepresented claimants will not avail themselves of their legal rights to dispute UR determinations, allowing defendants to sit on a claim with no hope of treatment, with only the minimal financial penalty of the cost of the review. Worse still, the routine and anticipated denials of care lead many unrepresented claimants to the understandable conclusion that it would be better to take the low settlement offer from the defendants, which likely will not consider needed medical care that is caught up in the bureaucracy.

To obtain a good result from the medical treatment, and a fair value for a claimant's workers' compensation claim, it is mandatory that claimants are advised or assisted in challenging incorrect decisions using all available legal remedies and ensuring that all legal avenues of appeal of adverse decisions are pursued and paid for by the defense. Only by holding defendants accountable in this regard will they be made to view utilization review as an expense *in addition to* the treatment costs of a claim, rather than a way to prevent them.

### Medical-legal process

At any time during the course of a claim, though oftentimes arising during the initial claim investigation period, a notice will go out that triggers the timeframes for selecting the specialty of the medical legal physician who will have the greatest impact on the results of a claim form. Labor Code section 4062.1 applies to unrepresented injured employees and grants them the exclusive right to submit a request for a panel of Qualified Medical Examiners (QME) in a specialty of their choosing within 10 days of the issuance of the benefit notice (extended by five, 10, or 20 days for service by means other than personal service). Once a panel has issued the benefit notice, the unrepresented employee has the exclusive right to select a physician from the QME panel within 10 days of its issuance, which is extended

by the corresponding timeframes for service by mail. Failure to exercise either or both of these rights allows the defendants to submit the request for a QME panel in the specialty of their choosing and select the most favorable physician from that list.

### Know the deadlines and extensions

A significant percentage of claims administrators operate with out-of-state addresses, which can result in a delay in an injured employee's receipt of the triggering notice, often arriving after the expiration of the 10 days, to act noted in the letter. While an attorney should know that service of a document by mail automatically includes an extension of time, for many injured employees they simply see the date on the letter and figure they have missed their opportunity. Even if they were to understand that there is an extension of time, would they know that although service of a document from outside of California to an address inside the state normally adds 10 additional days to act under Code of Civil Procedure section 1013, however the distinct workers' compensation "mailbox rule" is actually governed by California Code of Regulations section 10605 which extends the time only by five days when the recipient is within California regardless of the place from which the document was mailed?

Selection of an appropriate specialty for a QME panel, and of a doctor from that panel, is one of the most important decisions that arises in a claim. Certain specialties generally provide opinions more favorable to one side or the other. In practice, the unrepresented claimant is provided significant advantages at this stage of discovery, if they act timely. If the defendants are able to obtain a QME panel in their preferred specialty, and schedule an examination with their preferred doctor, the unrepresented employee has only two options: succumb to unfairness of the process and partici-

pate in discovery, or quickly obtain counsel who can acquire a replacement of this QME panel pursuant to *Romero v. Costco Wholesale* (2007) 72 CCC 824.

### Don't miss this opportunity

For claimants with related civil claims, it should be noted that defendants bear all of the costs of discovery and the medical legal process in a workers' compensation case. An unrepresented claimant, as well as a represented one, has a fantastic opportunity to generate a favorable medical-legal record, on the defendant's dime, which is generally admissible across multiple claims. Unfortunately, the system is set up in such a way that this opportunity is obfuscated, and the time to seize upon it has lapsed before they were even aware.

### Conclusion

The workers' compensation system is foreign and complex to those who have not experienced it. The system assumes that the majority of claimants will be navigating it without an attorney. Unfortunately, the complex technical requirements and procedures put in place to ensure defendants do not take advantage of legally unsophisticated claimants have the opposite effect and are used by defendants to frustrate claimants and deny benefits. The system is designed to give claimants the benefit of the doubt, and require defendants to bear the costs of the process. In the rare event that an unrepresented claimant successfully navigates the system, the results for them can be extremely fruitful. However, successful navigation of this complex system generally requires extensive knowledge of the statutes to effectuate it, and a lot of patience to persevere. While the system is designed to convey the idea that it is simple and streamlined, defendants count on this misconception to their benefit. Ultimately, only representation by experienced counsel can ensure that a claimant receives the full benefits that the workers' compensation system was created to provide.



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