# WORKERS' COMPENSATION BENEFIT SUMMARY

## TEMPORARY DISABILITY [L.C. 4453(A)]

| Effective Date | Avg Wkly Min Earnings | Minimum Wkly TD Rate | Avg Wkly Max Earnings | Maximum Wkly TD Rate |
|---|---|---|---|---|
| 1/1/06 | $189 | $126 | $1260 or 1.5 times the SAWW | $840 |
| 1/1/07 | $198.38 | $132.25 | $1,322.49 | $881.66 |
| 1/1/08 | $206.18 | $137.45 | $1,374.46 | $916.33 |
| 1/1/09 | $215.55 | $143.70 | $1,437.01 | $958.01 |
| 1/1/10 | $222.00 | $148.00 | $1,480.04 | $986.69 |
| 1/1/11 | $222.00 | $148.00 | $1,480.04 | $986.69 |
| 1/1/12 | $227.35 | $151.57 | $1,515.74 | $1,010.50 |
| 1/1/13 | $240.00 | $160.00 | $1,600.07 | $1,066.72 |
| 1/1/14 | $241.78 | $161.19 | $1,611.96 | $1,074.64 |
| 1/1/15 | $248.22 | $165.49 | $1,654.94 | $1,103.29 |
| 1/1/16 | $253.88 | $169.26 | $1,692.65 | $1,128.43 |
| 1/1/17 | $263.81 | $175.88 | $1,758.86 | $1,172.57 |
| 1/1/18 | $273.42 | $182.29 | $1,822.91 | $1,215.27 |
| 1/1/19 | $281.54 | $187.71 | $1,877.07 | $1.251.38 |
| 1/1/20 | $292.36 | $194.91 | $1,949.15 | $1,299.43 |
| 1/1/21 | $305.16 | $203.44 | $2,034.47 | $1,356.31 |
| 1/1/22 | $346.42 | $230.95 | $2,309.56 | $1,539.71 |
| 1/1/23 | $364.28 | $242.86 | $2,428.61 | $1,619.15 |
| 1/1/24 | $305.16 + the percent increase in the SAWW | $203.44 + the percent increase in the SAWW | $2,034.47+ the percent increase in the SAWW | $1,356.31 + the percent increase in the SAWW |

**Important Note**: Labor Code 4661.5 states that when temporary disability is paid two years or more from the date of injury, the amount of the TD payment shall be calculated based on the AWW in effect on the date of the temporary disability payment, unless the computation produces a lower payment. For benefits that commence on or after 4/19/04, there is an aggregate limit of 104 weeks within a two-year period [L.C. 4656(c)]. For dates of injury on or after 1/01/08, there is an aggregate limit of 104 weeks within five years from the date of injury [L.C. 4656(c)(2)].

**Volunteers and Hourly Wage Earners**: Note that effective for injuries on or after January 1, 2003, there is now a minimum TD rate regardless of wages [L.C. 4453(a)(8)].

## PERMANENT PARTIAL DISABILITY [L.C. 4453(A)(8-10)]

| Effective Date | PD < 15% | PD 15 –24.75% | PD 25 – 69.75% | PD 70-99.75% |
|---|---|---|---|---|
| 1/1/03 | $100 minimum<br>$185 maximum | $100 minimum<br>$185 maximum | $100 minimum<br>$185 maximum | $100 minimum<br>$230 maximum |
| 1/1/04 | $105 minimum<br>$200 maximum | $105 minimum<br>$200 maximum | $105 minimum<br>$200 maximum | $105 minimum<br>$250 maximum |
| 1/1/05 | $105 minimum<br>$220 maximum | $105 minimum<br>$220 maximum | $105 minimum<br>$220 maximum | $105 minimum<br>$270 maximum |
| 1/1/06-12/31/12 | $130 minimum<br>$230 maximum | $130 minimum<br>$230 maximum | $130 minimum<br>$230 maximum | $130 minimum<br>$270 maximum |

## PERMANENT PARTIAL DISABILITY ON/AFTER 1/1/2013 [SB 863]

| Effective Date | PD < 55% | PD 55 – 69% | PD 70 – 99% |
|---|---|---|---|
| 01/01/13 | $160 minimum<br>$230 maximum | $160 minimum<br>$270 maximum | $160 minimum<br>$290 maximum |
| 01/01/14 and after | $160 minimum<br>$290 maximum | $160 minimum<br>$290 maximum | $160 minimum<br>$290 maximum |

**Important Notes**: For injuries on/after 1/1/05, permanent disability determinationsare based on AMA guidelines with consideration for loss of earning capacity. Employers with 50 or more employees – if unable to return employee to work within 60 days of permanent and stationary determination, employee will receive a **15% increase** in permanent disability payments. Regardless of size of employer, employees who are made an offer to return to regular, modified, or alternative work and returned within 60 days of a permanent and stationary determination will receive a **15% decrease** in permanent disability payments. Regular, modified or alternative work must be within 85% of the salary at date of injury and last for at least 12 months.

Under SB 863, PD determinations based on diminished earning capacity and the 15% increase/decrease were repealed for dates of injuries on/after 1/01/13.

## PERMANENT TOTAL DISABILITY [L.C. 4453 (A) (8-10) & L.C. 4659]

| Effective Date | Avg Wkly Min Earnings | Minimum Wkly PPD Rate | Avg Wkly Max Earnings | Maximum Wkly PPD Rate |
|---|---|---|---|---|
| 1/1/06 | $189 | $126 | $1260 or 1.5 times the SAWW | $840 |
| 1/1/07 | $198.38 | $132.25 | $1,322.49 | $881.66 |
| 1/1/08 | $206.18 | $137.45 | $1,374.46 | $916.33 |
| 1/1/09 | $215.55 | $143.70 | $1,437.01 | $958.01 |
| 1/1/10 | $222.00 | $148.00 | $1,480.04 | $986.69 |
| 1/1/11 | $222.00 | $148.00 | $1,480.04 | $986.69 |
| 1/1/12 | $227.35 | $151.57 | $1,515.74 | $1,010.50 |
| 1/1/13 | $240.00 | $160.00 | $1,600.07 | $1,066.72 |
| 1/1/14 | $241.78 | $161.19 | $1,611.96 | $1,074.64 |
| 1/1/15 | $248.22 | $165.49 | $1,654.94 | $1,103.29 |
| 1/1/16 | $253.88 | $169.26 | $1,692.65 | $1,128.43 |
| 1/1/17 | $263.81 | $175.88 | $1,758.86 | $1,172.57 |



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|---|---|---|---|---|
| 1/1/18 | $273.42 | $182.29 | $1,822.91 | $1,215.27 |
| 1/1/19 | $281.54 | $187.71 | $1,877.07 | $1.251.38 |
| 1/1/20 | $292.36 | $194.91 | $1,949.15 | $1,299.43 |
| 1/1/21 | $305.16 | $203.44 | $2,034.47 | $1,356.31 |
| 1/1/22 | $305.16 | $203.44 | $2,034.47 | $1,356.31 |
| 1/1/23 | $364.28 | $242.86 | $2,428.61 | $1,619.15 |
| 1/1/24 | $305.16 + the percent increase in the SAWW | $203.44 + the percent increase in the SAWW | $2,034.47+ the percent increase in the SAWW | $1,356.31 + the percent increase in the SAWW |

## LIFE PENSION [L.C. 4659]

| | |
|---|---|
| **7/1/96 through 12/31/05 MAX. AVERAGE WEEKLY WAGE** | $257.69 |
| **Effective as of 1/1/06 MAX. AVERAGE WEEKLY WAGE** | $515.38 |

**Important Note:** For dates of injury on or after January 1, 2003, L.C. 4659(c) requires the life pension payment be increased each year by the percentage increase in the State Average Weekly Wage commencing January 1, 2004. **Life pension applies when permanent disability exceeds 70%.**

## DEATH BENEFITS [L.C. 4702]

| Dependents | Dates Of Injury 7/1/96 – 12/31/05 | Dates Of Injury 1/1/06 |
|---|---|---|
| 1 TOTAL | $125,000 | $250,000 |
| 2 TOTAL | $145,000 | $290,000 |
| 3 or More TOTAL | $160,000 | $320,000 |
| 1 TOTAL plus 1 or more PARTIAL | $125,000 plus 4x annual support not to exceed $145,000 | $250,000 plus 8x annual support not to exceed $290,000 |
| NO TOTAL and 1 or more PARTIAL | 4x annual support not to exceed $145,000 | 8x annual support not to exceed $250,000 |
| NO DEPENDENTS | $125,000 to the State (if no estate) | $250,000 to the estate |

Effective 01/01/13, burial expenses may be payable up to $10,000. Prior to 01/01/13, burial expenses were payable up to $5,000.

## SUPPLEMENTAL JOB DISPLACEMENT BENEFITS [L.C. 139.5, 4658.5]

For injuries on/after 01/01/04, employees who do not return to work for their employer within 60 days of the end of TD period may be eligible to receive a voucher of $4,000 for permanent partial disability of less than 15%; $6,000 for permanent partial disability between 15% and 25%; $8,000 for permanent partial disability between 26% and 49%; and $10,000 for permanent partial disability between 50% and 99%. The voucher must be used at State-approved or accredited schools for education-related retraining or skill enhancement, or both.

For injuries on/after 01/01/13, employees who do not return to work for their employer within 60 days of receipt of the physician's report of permanent and stationary status may be eligible to receive a voucher of up to $6,000. The voucher must be used at State-approved or accredited schools for education-related retraining or skill enhancement, or both. The voucher may also be used to purchase computer equipment up to $1,000 and $500 for miscellaneous expense.

Employer will not be liable for the supplemental job displacement benefit if, within 30 days of the end of TD, offers modified or alternative work, lasting at least 12 months.

The supplemental job displacement voucher will expire after two years of issuance. Also, the voucher cannot be settled for cash.

## MEDICAL FEE SCHEDULE [L.C. 5307.1]

Except for physician services, all fees shall be in accordance with the fee-related structure and rules relevant to Medicare and Medi-Cal. 100% of Medi-Cal for pharmaceuticals. Inpatient hospital at 120% of Medicare, 120% of the Medicare hospital outpatient department fee for hospital outpatient departments and ambulatory surgery centers; these provisions become effective for dates of services on and after 1/1/04.

On/after 01/01/14, the physician fee schedule shall be in accordance with the Resource-Based Relative Value Scale.

## MEDICAL TREATMENT [L.C. 5402]

Medical treatment must be authorized within one working day of receipt of Employee Claim Form (DWC-1) until compensability decision is made (subject to $10,000 cap). Applies to all claim forms received on or after 4/19/04.

## UTILIZATION REVIEW [L.C. 4610, SB 1160]

Requires all employers to adopt utilization review systems, either directly or through an insurer or entity with which an employer or insurer contracts for services. Procedures must be consistent with the Medical Treatment Utilization Schedule (MTUS) or ACOEM (American College of Occupational and Environmental Medicine) or other nationally recognized utilization review schedule.

Effective for dates of injury on/after January 1, 2018 medical treatment, for admitted injuries, provided by a Medical Provider Network (MPN) is not subject to utilization review the first 30 days following the date of injury. There are certain exceptions including: pharmaceuticals not authorized by a drug formulary, nonemergency inpatient/outpatient surgery, psychological treatment, home health care, imaging/radiology (excluding x-rays), durable medical equipment, EMG's/nerve conduction studies).

## INDEPENDENT MEDICAL REVIEW (IMR) [SB863, L.C. 139.5, 4610.5]

For injuries on/after 01/01/13 and utilization review decisions communicated after 07/01/13, if the injured worker objects to a determination issued by utilization review to modify, delay, or deny a request for authorization of a medical treatment requested by the treating physician, the issue shall be resolved only by the independent medical review process through the Administrative Director. Fees for IMRs submitted on/after 01/01/2015 range from $390-$515. The previous range was $495-$850.

If the employee objects to the diagnosis or recommendation for medical treatment by a physician within the medical provider network, the issue shall be resolved only by the independent medical review process.

## PERSONAL PHYSICIAN DESIGNATION [L.C. 4600]

The personal physician must be the employee's primary treating physician and is limited to the following specialties: internist, family practitioner, general practitioner, OB/GYN, or pediatrician. The personal physician may also be a medical group if that medical group is multi-specialty and primarily non-occupational. The physician must agree in writing.

## PERSONAL CHIROPRACTOR DESIGNATION [L.C. 4601]

If no MPN is in place, the employee can designate their personal chiropractor or acupuncturist, but must specifically request a change of physician after initially treating with the employer selected physician.

However, a chiropractor can no longer be a primary treating physician after 24 chiropractic office visits, even if the chiropractic treatment does not include chiropractic manipulation.

## LIMIT ON CHIROPRACTIC TREATMENT, PHYSICAL THERAPY & OCCUPATIONAL THERAPY [L.C. 4604.5(D)]

For dates of injuries after 1/01/04, chiropractic, physical therapy and occupational therapy visits are limited to 24 visits per injury. This cap does not apply post-surgery (only for dates of injury on or after 1/1/08) or if the claims administrator or employer authorizes, in writing, additional visits [L.C. 4604.5(d)(3)].

## SPINAL SURGERY SECOND OPINION [L.C. 4062 (B)]

The second opinion spinal surgery process is repealed effective 1/01/13 (SB863). Spinal surgery issues will be addressed under utilization review and/or the independent medical review process (IMR).

## MEDICAL PROVIDER NETWORKS [L.C. 4616, ET SEC.]

Effective 1/1/05, employers "may" establish a medical provider network and have exclusive control over the establishment of the network. Employee is entitled to three opinions within network to resolve certain disputes. After a third opinion, the State assigns an Independent Medical Reviewer (IMR) to examine and render a binding opinion.

Effective 1/01/14, a physician must agree to be part of an established medical provider network.

## LIENS [L.C. 4903, ET SEC, SB863 AND SB 1160]

There is now a $150 filing fee for liens filed on/after 1/01/13 for medical treatment, medical-legal expenses or claims costs. As of November 19, 2013, the DWC stopped collecting $100 activation fees for liens filed prior to 1/01/13 pending the outcome of the case, Angelotti Chiropractic vs. Christine Baker, DWC that was filed in the U.S. District Court of Appeals, Ninth Circuit.

On June 29, 2015, the Ninth Circuit Court of Appeals held that the Legislature establishing the $100 activation fee was well within its constitutional authority; and therefore vacated the injunction which prohibited the Department of Industrial Relations from enforcing the activation fee.

## INDEPENDENT BILL REVIEW (IBR) [L.C. SECTION 139.5]

Effective 1/01/13, if a medical provider disagrees with a payment recommendation issued by the claims administrator, the provider may request an independent bill review through the Administrative Director within 30 days of the final payment.

The medical provider is required to pay a fee for the IBR in the amount of $325. If the IBR determines that additional payment is due, the medical provider must be reimbursed the $325 fee.