PENTARISK PERSPECTIVES

California Edition

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Workers' Compensation Claim Initially Denied, then Accepted. Why?

I've heard it many times, "I thought this workers' compensation claim was denied, so why is it still open?" The fact of the matter is, most workers' compensation denials are challenged by the claimants. The claims just don't go away. When a claims administrator or insurer sends a denial letter, it includes the State of California's mandatory language: *You have the right to disagree with decisions affecting your claim. You also have the right to be represented by an attorney of your choice*. In the letter, the employee is then directed to The Division of Workers' Compensation website for additional information on their rights, and how to proceed with a Panel Qualified Medical Evaluation (QME) process. In essence, when their claims are denied, employees are literally advised how to appeal the decision.

Please keep in mind that some workers' compensation claims are denied simply because of inadequate information, not because a thorough investigation determined the employee was not injured at work. Once further information is obtained, including a panel QME (an expert medical opinion), denials are often overturned.

Most Denied Claims Later Become Accepted:

Nationwide two-thirds of all denied claims later become accepted claims, and worst yet, those accepted claims now cost substantially more to settle. Why? Lawyers are hired to fight the denials and then they stay on to conclude the matters. More money out of your insurer's pocket as the lawyers add on new injuries and other issues.

It is no secret that the California workers' compensation system supports the employee, not the employer. In fact, California Labor Code Section 3202 maintains that certain sections of the labor code "shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." That appeal process is more likely to undermine the initial claim denial by giving the employee the benefit of the doubt.

Accident Investigations:

After the employee alleges that an injury was in the course and scope of his employment, it is the employer's burden to prove otherwise. It is in your company's best interest to work alongside the insurance company in their investigation. Respond to their requests for communication and information timely. Conduct your own post-accident investigation. Gather as much information as possible after the injury allegation. How did the accident occur, who was the employee working with at the time, and did anyone witness the injury? What are the employee's complaints? Are you aware of any prior injuries, does the employee play sports or have other employment? What is the status of their employment? Are things slowing down at your company? Are there any personnel issues? Take photos of the accident scene. The more information you can pass onto your claim administrator, the better.

Possible Outcomes:

To prove fraud, you need substantial evidence to prevail at the WCAB. The best evidence would be for you to have solid proof that the accident did not happen at all. On the flip side, even great evidence will many times fail you.

In California, Pearson Ford (Pearson) and its insurer developed evidence that Pearson's employee was taking advantage of the workers' compensation system, exaggerating his claim. The employee slammed his hand closing a car trunk, no broken bones. He collected workers' compensation benefits from 2006 to 2010. Surveillance was performed and a District Attorney took an interest in the case. The employee was charged with insurance fraud. He plead guilty and he was placed on probation and was required to pay $9,000 in restitution. Unfortunately, the claim did not end there. The employee's medical condition was reevaluated by another doctor after his conviction. On May 31, 2016, a workers' compensation judge, relying on the new doctor's testimony, agreed that the employee sustained 70% permanent disability. The judge awarded him a life pension and future medical benefits—a horrible loss for Pearson and its insurer.

The employee in this matter was convicted of exaggerating his injury. Nevertheless, he was entitled to benefits despite his misrepresentations because there was convincing medical evidence that his injury later resulted in a permanent disability. It can be argued that this outcome is really disturbing, but it does not stand for the proposition that an employee can present a fake injury to collect benefits.

Ninety-Day Time Frame to Confirm or Deny Claim:

An insurer has 90 days to complete an investigation from the date of the employer's knowledge of the injury, not from when the claim was reported to the insurer. Report any disputed or potentially fraudulent claim to your insurance carrier as soon as you become aware of it. This means making sure your supervisors and foremen understand how important it is to timely report any allegation of injury or pain from an employee. Be sure to express that the claim is disputed when reporting the claim to your carrier. Only the claims administrator or insurer can deny a workers compensation claim. Do not take matters into your own hands if you think a claim is not warranted. Why? The claim will become automatically compensable 90 days after your knowledge of it, so delayed reporting to your insurer reduces its time to conduct a full investigation.

In California, an employee is entitled to up to $10,000 in medical treatment while a claim is waiting for the conclusion of an investigation. This can actually be beneficial to you when the employee has the benefit of medical treatment and modified duty, and has ultimately recovered from his injury before the decision on his claim has been made. An employee is unlikely to appeal since he has recovered physically and there are no lost wages to pursue.

One Year Time Frame:

Did you know that an employee has one year to report a workers' compensation claim? Even if the employee quits, has been laid off, or even terminated in some circumstances. It does not bar an employee from pursuing an alleged injury that occurred months before. Sometimes if the employer was aware of the injury and did not provide a DWC1 claim form or advise the employee of their rights to file a claim, the employee could file outside of the one year statute. The employer has a duty to provide a DWC1 claim form to an injured worker within 24 hours after an injury is alleged.

Seven Critical Steps After an Injury:

1. Investigate immediately. Determine how, when and where this happened, who the witnesses are, and what you know about your employee. Did a third party or equipment cause the accident?

2. Direct the employee to YOUR industrial medical clinic (Medical Provider Network); cost containment for his medical treatment is the issue.

3. Report the claim timely, get your broker involved if there is a potential dispute.

4. Stay in touch with the injured worker. Being engaged sometimes pays dividends.

5. Communicate with your adjuster.

6. Document all details of the accident; you may need it for trial.

7. Offer modified duty only when appropriate.

The legal determination of a disputed claim will come down to medical facts and the QME opinions, not yours. Remember that there is a bias for all injured workers at the WCAB. The labor code actually mandates that when in doubt the benefit goes to the injured worker, not the employer. Accordingly, in California the odds are stacked against the employer, so it is best to have ironclad evidence to ensure that a claim denial is upheld.

Your ultimate defense to avoid claims is to have good hiring practices and a great safety program!

For more information on this topic, please contact:

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Please refer to the following *Perspectives* articles for related topics at www.pentarisk.com:

Firing Injured Workers—Recipe for Disaster? — February 2019

Temporary / Permanent Modified Duty — January 2019

Modified Duty: Five Best Practices — November 2018

To Offer Temporary Modified Duty or Not — September 2018