California Coalition on Workers' Compensation
California Chamber of Commerce
California State Association of Counties
Association of California Insurance Companies
California Restaurant Association
California Hospital Association
California Manufacturers & Technology Association
National Federation of Independent Business

May 30, 2013

Maureen Gray
Regulations Coordinator
Department of Industrial Relations
P.O. Box 420603
San Francisco, CA 94612

RE: Proposed Regulations: Supplemental Job Displacement Benefit Voucher

Dear Ms. Gray,

The above-listed organizations thank you for the opportunity to provide feedback on the proposed regulations for the Supplemental Job Displacement Benefit Voucher. Combined, our organizations represent tens of thousands of insured and self-insured public and private sector California employers and insurance companies.

While there have been several estimates of the savings associated with SB 863 (De Leon, 2012), it is clear that the ultimate impact on employers (large and small, insured and self-insured) will depend largely on the implementation work that takes place over the next several months at the Department of Industrial Relations, the Division of Workers' Compensation (DWC), the Office of Self Insurance Plans, and the Workers' Compensation Appeals Board. The above-listed organizations are dedicated to working collaboratively with regulators throughout the implementation process to ensure that employers across California receive the relief anticipated during the passage of SB 863 (De Leon, 2012).

Our coalition would like to thank you for considering and accepting some of the more important recommendations contained in the March 19, 2013 letter from this coalition. Most importantly, our coalition would like to thank you for modifying § 10133.31(c) to clarify that an injured worker that has a) lost no time, or b) returned to the same job for the same employer is deemed to have been offered regular work. This will ease the compliance burden on employers without jeopardizing benefits for injured workers.

Employees who quit or are terminated for cause

Our coalition would like to recommend the addition of language in § 101331.34 that would clarify that an employer is not liable for a Supplemental Job Displacement benefit Voucher in situations where an offer of regular, modified, or alternative work was not made because a) the employee voluntarily quit employment, or b) the employee was terminated for cause. In both of these situations it would be inappropriate to penalize an employer for not offering regular, modified, or alternative work. If an employee has voluntarily left employment and the employer has had to backfill that position in order to effectively continue operations, the employer should not be forced to bring that employee back to work or pay a financial penalty when they had no power over the employee's original decision to leave employment. Similarly, an employer should not be penalized in a situation where they have terminated an employee for cause. Our coalition strongly supports a modification to the regulation that would reflect this reality.

Mockup of Physician's Return to Work & Voucher Report

Our coalition has modified the proposed Physician's Return to Work & Voucher Report and the accompanying instructions. The mocked-up forms are enclosed for your review. Our coalition eliminated the checklist of activities for the form because we felt that it is confusing. Specifically, it is unclear whether the checklist is for functions that the employee is capable of performing, or restricted from performing. If you maintain the checklist, the purpose should be clarified.

Thank you once again for the opportunity to comment on the proposed regulation. If you have any questions, please feel free to contact Jason Schmelzer with the California Coalition on Workers' Compensation (916-441-4111) Jeremy Merz with the California Chamber of Commerce (916-930-1227).

Sincerely,

Jason Schmelzer
CCWC

Jeremy Merz
CalChamber

Enclosure

cc. David Lanier, Chief Deputy Legislative Secretary, Office of Governor Edmund G. Brown
Christine Baker, Director, Department of Industrial Relations
Destie Overpeck, Acting Administrative Director, Division of Workers' Compensation

Enclosure 1

Physician's Return-to-Work & Voucher Report

FOR INJURIES OCCURRING ON OR AFTER 1/1/13

Employee Last Name | Employee First Name | MI | Date of Injury

Claims Administrator: | Claims Representative:

Employer Name: | Employer Street Address:

Employer City: | State: | Zip Code: | Claim Number:

All conditions have reached P&S or MMI: ◯ Yes ◯ No If no, do not complete this form.

Is permanent disability present: ◯ Yes ◯ No If no, do not complete this form.

The employee can return to work with no restrictions: ◯ Yes ◯ No If yes, STOP HERE.

If the employee is not able to return to regular work duties because of permanent work restrictions due to the work injury(ies), please describe the permanent work restrictions. These restrictions will be provided to the employer to determine if permanent modified or alternate work is available for the employee.

Please describe the employee's work activity restrictions:

If a Job Description has been provided, please complete this section:

Job Title: | Work Location:

TYPE OF DUTIES: ☐ Regular ☐ PROPOSED Modified ☐ PROPOSED Alternative Work

Are the Work Duties set forth in the provided job description compatible with the activity restrictions? ◯ Yes ◯ No, explain below

Physician's Name: | Role of Doctor (PTP, QME, AME)

Physician's Signature: | Date:

Enclosure 2

State of California, Division of Workers' Compensation
Retraining and Return to Work Unit

Physician's Return-to-Work & Voucher Report Instructions
FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC - AD 10133.36

What is the purpose of this form? The purpose of the form is to fully inform the employer of the permanent work activity restrictions resulting from the work injury that are relevant to potential regular work, modified work, or alternative work. The information contained on this form is for voucher purposes only and shall not be considered in any permanent impairment rating or in determining eligibility for permanent disability indemnity benefits.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

Who is responsible for filling out this form? The first physician (primary treating physician, Agreed Medical Evaluator, or Qualified Medical Evaluator) who finds that the medical condition(s) for all injuries for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) **and** finds that the injury has caused permanent partial disability must complete this form. If the employee has returned, or is able to return to regular work, completion of this form beyond the first section is not necessary.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

The physician should describe the employee's work restrictions in terms of how many hours a particular restricted activity can be performed during an 8-hour work day. For restrictions to extremities, the physician should indicate whether the restrictions are for the right, hand, or both.

If the employer or claims administrator has provided the physician with a job description outlining the physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician shall evaluate and describe in this form whether the employee's work restrictions are compatible with the physical requirements set forth in that job description. The Job Description section of the form does not need to be completed if the physician has not been provided with a job description.

How does the employer receive the form? The claims administrator shall forward the completed form to the employer.