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Workers' Compensation

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a LANGE medical book
CURRENT
Occupational &
Environmental Medicine

FIFTH EDITION

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McGraw
Hill
Medical

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Virtually every industrialized country provides legislated entitlements to workers or their survivors to assist them in the event of an occupational injury or illness. Workers' compensation systems are designed to ensure that the injured worker not only receives immediate medical care, but also prompt but limited benefits to replace lost wages. Workers' compensation provides only part of the entitlement, with the rest—particularly for long-term disability, contributed indirectly through the country's social security system. Workers' compensation insurance assigns sure and predictable, “no-fault” liability to the employer.

Physicians and other health care providers who render care for work-related injuries and illnesses should understand the requirements of their jurisdiction's workers' compensation system. In addition to appropriate evaluation, diagnosis, and treatment, physicians are obligated to determine whether a worker's injury or disease claim was specifically caused by work activity—a process that often engenders an adversarial relationship between the physician, the patient, and the responsible party, that is, the insurer and the employer. Physicians must provide services efficiently because they are accountable not only to their patient (the injured or ill worker) to alleviate suffering and to ensure the flow of benefits, but also to the insurer and the employer to minimize disability, lost work time, and costs associated with occupational injury or illness.

WORKERS' COMPENSATION LAW

The financial responsibility of the employer for the injury or death of an employee in the workplace was first established in Germany in 1884. Great Britain followed, in 1897, with legislation requiring employers to compensate employees or their survivors for an injury or death regardless of who was at fault. By the beginning of the twentieth century, all European countries had workers' compensation laws.

The German law provided a model of workers' compensation that was ultimately emulated by most European countries. The German system called for highly centralized administration of workers' compensation claims and disbursements. It provided for accident prevention, medical treatment, and rehabilitation. Its coverage was broad and compulsory by all employers. The law mandated that the insurance be proffered to employers by nonprofit mutual employers' insurance funds. The German system was closely linked to the rest of the nation's social insurance system.

The British law embodied a substantively different approach. Participation by employers was elective, administration was left to the judicial system, and insurance was offered to employers through private firms. The British system was not linked to the nation's social insurance system, and it did not provide for accident prevention, medical treatment, or rehabilitation. The British system was troubled from the outset by disputes over which jobs and what industries were to be covered, resulting in the very litigation that the law had been intended to replace.

There is a high degree of similarity between the basic criteria of the current workers' compensation systems in all European countries. Some European social security systems provide universal coverage for disability, regardless of whether it was caused or aggravated by work. Under this system, there is no specific insurance against employment injuries and occupational diseases. This form of social insurance provides wage replacement covering the loss of earnings due to old age, unemployment, temporary sickness, and/or permanent disability. For example, all workers in the Netherlands, Sweden, and Germany are covered against the risk of wage loss due to temporary sickness through government agencies. Coverage typically lasts up to 1 year, while transition is made to longer-term disability insurance programs if needed. In the Netherlands, partially disabled unemployed workers are given the same benefits as totally disabled workers.

US WORKERS' COMPENSATION

The workers' compensation movement did not begin in the United States until 1908, when a forerunner of the Federal Employees Compensation Act (FECA) was passed. In the United States, two separate and distinctly different workers' compensation systems, federal and state, function independently of one another.

► Federal Workers' Compensation

The Federal Employees' Compensation Act (FECA) provides federal government employees who are injured in the performance of duty with workers' compensation benefits. These include wage-loss benefits for total or partial disability, monetary benefits for permanent loss of use of a body part, medical benefits, and vocational rehabilitation. FECA also provides survivor benefits to eligible dependents of workers who died as a result of a workplace injury or occupational disease.

The FECA is administered by the Office of Workers' Compensation Programs (OWCP) within the U.S. Department of Labor (DOL). FECA covers over 2.7 million federal employees in more than 70 different agencies, such as the U.S. Postal Service (USPS), the Department of Homeland Security, and the Department of Veterans Affairs. In addition, FECA covers a number of other worker groups adopted by Congress in various acts of expansion of the federal authority, namely military personnel, Longshore-Harbor workers, atomic energy workers, coal workers' pneumoconiosis ("black lung") victims, and others. Military personnel constitute by far the largest federal program in workers' compensation.

The federal system followed the German comprehensive model. FECA provides benefits without delay, and moves disabled workers to other government entitlement programs, including retirement, with relative ease. As a federally administered system, the FECA program operates without competition. The Secretary of Labor has exclusive jurisdiction over the entire program, including the various appeal and review processes. The DOL has few constraints on what it charges the federal agencies for workers' compensation benefits or medical care. The DOL passes on all its FECA costs to Congress, plus additional fees that are seldom reviewed for consistency. Most federal agencies include workers' compensation costs in their annual appropriation requests to Congress, which effectively buries the expenditures.

► State Workers' Compensation

When workers' compensation laws were gradually adopted by each state, they largely followed the less comprehensive British model. In 46 states, all or most workers' compensation

insurance is currently provided by private insurance companies. Workers' compensation programs, with some important exceptions, are state-regulated, with laws determined by each state legislature and implemented by a state agency. The programs provide the payment of lost wages, medical treatment, and rehabilitation services to workers who have sustained an occupational injury or disease. Private insurers and self-insured employers administer the system on a day-to-day basis, authorizing which physicians and other medical providers can participate, accepting or denying claims, and paying benefits to injured workers and medical providers.

While there have been many hundreds of minor redesigns implemented by each of the 50 state workers' compensation programs in the past century, overall there have been few major reforms ever initiated or adopted by either government or industry.

► Characteristics of State Workers' Compensation Systems

A. No-Fault Principle and Exclusive Remedy

Employers' responsibility under the workers' compensation system for providing medical treatment and compensation benefits for employees injured at work or made ill from exposure to the workplace environment is based on a premise of liability without fault. Regardless of whether the worker, the employer, or neither is at fault, the employer is still responsible for providing medical treatment and compensation benefits to the injured employee.

A basic tenet of workers' compensation laws and the programs administered to implement them is that workers should receive quick and sure, though limited, payments for occupational injuries, and to assign to the employer sure and predictable liability for such payments. In return, benefits injured workers receive are their "exclusive remedy." The exclusive remedy principle is the *quid pro quo* under which the employer enjoys immunity from being sued, in exchange for accepting absolute liability for all occupational injuries and illnesses. The injured worker cannot sue his/her employer, however, severe or permanent the work-related injury or illness, and regardless of the extent or circumstances of the extent of either the worker's or employer's culpability or negligence that led to the injury or illness.

B. Causation Test

To receive compensation under all state workers' compensation laws, a worker's injury or illness must "arise out of and in the course of employment" (AOE/COE). FECA uses the phrase "sustained while in the performance of duty." In all but the most obvious workplace injuries in most state the onus of proving causation is on the worker. Thus the success

of the claimant largely depends on the validity, accuracy, and objectivity of the treating physician's evaluation and diagnosis. A work injury or illness that is determined to activate (accelerate) or aggravate a preexisting medical condition also is compensable in many states—though this definition varies by state and is subject to change with each elected legislature. Recurrence of an earlier compensable injury is also compensable. In some states, an injured worker may have a limited time period in which to “re-open” a closed claim, whereas in other states the worker is granted “lifetime reopening rights.” Depending on the jurisdiction, judicial action may be necessary to resolve questions of liability for self-inflicted injuries and suicidal acts. Similar determinations may be necessary for injuries occurring under the influence of alcohol or drugs, during entirely personal activity (not AOE/COE), and for violence at work.

C. Benefits

The vast majority of occupational injuries are minor sprains, strains, and abrasions. These minor injuries are self-limited in nature and readily treated in workers who are almost universally disposed to return to work. Many such cases involve a temporary assignment of modified or restricted duty, during which time the worker does not receive disability benefits. Well over 90% of occupational injuries are temporary disability cases.

Of the 8.5 million occupational injuries reported in a single year in the United States, the vast majority (>6 million) do not involve time away from work. In these cases, the only benefits are payments made for medical care to physicians or other medical providers. Medical-only claims are not a major expense to the employer or insurer. Although they account for approximately 77% of workers' compensation claims, they constitute only 8% of all benefits paid.

The remaining 23% of cases, which include the more serious injuries and some occupational diseases, account for over 90% of worker benefits, medical care costs, and disability benefits. In the United States each year, more than 900,000 workers miss 1–4 days of work; more than 1 million experience temporary total disability; more than half a million have an injury that causes a permanent disability (partial in most cases); and more than 5600 experience a fatal injury on the job. Well over 90% of occupational injuries that are not “medical only” are “temporary partial disability” claims. Among the more serious injuries, 900,000 injured workers miss only 1–4 days of work.

1. Indemnity payments—Workers' compensation insurance for an accepted claim pays employees benefits (sometimes referred to as “cash benefits” even though they are in the form of a check) for lost work time after a 3- to 7-day waiting period. Payment of benefits to workers or their families are of six types: (1) temporary partial disability, (2) temporary total disability, (3) permanent partial disability,

(4) permanent total disability, (5) survivors' benefits, and (6) vocational rehabilitation benefits.

A. TEMPORARY PARTIAL DISABILITY—Temporary partial disability (TPD) occurs when a worker is injured to the degree that the worker cannot perform his or her usual work, but is still capable of working at some job during convalescence, usually with temporary restrictions or limitations (“modified duty,” assigned by the physician). Under this category, the injured worker is compensated for the difference between wages earned before the injury and wages earned during the period of temporary partial disability, usually at two-thirds of the difference, assuming the modified duty work is significantly different than the regular job assignment.

Many insurers and employers view modified duty as a critical element of the treatment plan and rehabilitation of these injured workers. Modified duty may save the worker from wage differentials by preventing the TPD payment. Some employers in certain industries nonetheless may refuse to allow an injured worker to return to work until he/she is cleared by the treating physician for “full duty.” In such cases, the worker is entitled to receive temporary total disability.

B. TEMPORARY TOTAL DISABILITY—The majority of injured workers receiving compensation are expected to recover with treatment and/or time, but are unable to work for some period of time. By law, these injured workers are entitled to receive temporary total disability (TTD) benefits. One million workers experience a temporary total disability.

TTD benefits are paid during the recovery period on the basis of the worker's average earnings. Minimum and maximum limits apply, and benefits of as much as two-thirds of gross salary or 80% of take-home wages are paid until the individual is able to return to work or reaches maximum recovery. There is a waiting period for this type of compensation, but it is paid retroactively if the worker cannot work for a certain number of days or if hospitalization is necessary. The waiting period serves as an incentive to return to work after less serious injuries. Thus, it is like a deductible provision in other forms of health insurance in which the worker shares some of the cost, despite the “no-fault” principle.

Temporary disability benefits—TPD and TTD—account for 63% of claims involving cash benefits, yet they represent only 16% of the benefits incurred, with the preponderance of such benefits allocated to permanent disability.

C. PERMANENT PARTIAL DISABILITY—Permanent partial disability (PPD) occurs when an injured worker is disabled to the point that he/she has lost some ability to compete in the open labor market. Injuries resulting in permanent impairments to body parts are typically compensated through the use of a “schedule,” that is, a list of injuries and

well-recognized occupational diseases specified in workers' compensation statutes which are translated into a percentage of loss of total body function. For example, 100% loss of an arm entitles the worker to 500 weeks of benefits, and 50% loss of an arm to 250 weeks.

Nonscheduled PPD benefits are paid for injuries not on the schedule list. Injuries to the spine that are permanently disabling are typically not scheduled, nor are injuries to certain internal organs, head injuries, and many occupational diseases. For unscheduled conditions, the approaches used can be categorized into four methods. Some states use an "impairment approach," which looks only at the medical consequences of the injury, and conflates impairment with disability. The benefit is based entirely on the degree of impairment. In states that use the "loss of earning capacity approach," disability evaluation considers medical consequences as well as factors such as age, education, and job experience that affect the worker's earning capacity. Under the "wage-loss approach," benefits are paid only if the worker also has actual wage loss due to work injury, after it has been determined that maximum medical improvement has been achieved. In the "bifurcated approach," payment of impairment or loss of earning capacity benefits depends on the worker's employment status at the time the worker's condition is assessed.

PPD cases account for more than half of all claims, typically where temporary disability has lasted more than 7 days. Permanent partial disabilities account for 36% of claims that involve cash payments, but constitute 67% of benefit payments.

D. PERMANENT TOTAL DISABILITY—Permanent total disability (PTD) covers workers who are so disabled from an occupational injury or disease that they will never be able to work again in an open labor market, and for whom further treatment offers no hope of recovery. Most states compensate such individuals with two-thirds of their average wages subject to minimum and maximum limits. Because benefits are not taxed, this can amount to approximately 85–90% of take-home wages. States also may provide additional funds for dependents. Although some states limit the duration of payments, others provide compensation for the remainder of the injured worker's life.

Permanent total disabilities, together with fatalities, account for only 1% of all cases that receive cash benefits, yet they account for 17% of total cash benefit payments. The medical costs per case are the highest by far for the 8200 who are permanently totally disabled by a workplace injury each year, averaging more than \$680,000 per case.

E. SURVIVORS' BENEFITS—Dependent survivors of employees killed 'on the job' are paid death benefits under workers' compensation. The method and size of payments vary widely among the various states, but all systems provide for a death benefit and some reimbursement for burial expenses.

Occupational diseases are responsible for more deaths than occupational injuries. However, many diseases that are probably associated with occupational exposures are either not recognized by the worker, his/her family, or the treating physician, or are disputed by the insurer or employer. Medical costs for deaths due to occupational diseases are sevenfold greater than the costs of injuries, estimated to be well over \$20 billion.

F. VOCATIONAL REHABILITATION BENEFITS—Vocational and psychological counseling or retraining and job placement assistance are typical benefits. Some level of rehabilitation is provided in all states even if unspecified by statute. The goal is to return the injured worker to suitable, gainful employment.

2. Benefits from other sources—A number of benefits are available to workers from other sources.

A. SOCIAL SECURITY DISABILITY INSURANCE (SSDI)—In the United States, the social security system is the main funding source for workplace disabilities outside of the workers' compensation insurance system.

For permanently and totally disabled workers, SSDI supplements workers' compensation with monthly benefits for disability. Such benefits are available only after a 5-month waiting period and are calculated as if the disabled individual had reached social security retirement age. To be considered disabled, the injured person must be unable to work in substantial gainful employment. Furthermore, the disability must be expected to last more than 1 year or to result in premature death. SSDI combined with workers' compensation cannot exceed 80% of the worker's average earnings or the total family benefit under social security before the injury. If the combined compensation does exceed this amount, social security benefits are reduced accordingly, although some states will reduce workers' compensation benefits by all or part of the social security payments.

The SSA deems disabilities to be "total and complete" if applicants demonstrate that their impairments prevent them from earning at least \$1000 a month. Presumptions of disability are based on age, education, work history, and other mitigating factors. Applicants are permitted to count the sum of multiple "nonsevere" impairments and count them as one "severe" disability.

The Social Security Administration (SSA) reports that 8.6 million workers and 2 million dependents receive disability payments each year. Workers pay \$104 billion into the program each year from payroll taxes, while the system pays out \$128 billion in benefits. The number of disability recipients grows at a rate twice as fast as the number of workers to support the system.

B. SECOND-INJURY FUNDS—Second-injury (also called "subsequent injury") funds compensate workers for injuries that are exacerbated by a subsequent injury to the same body

part or organ system. Some states' second-injury funds compensate workers for flare-ups that do not necessarily lead to total disability. These funds are established and maintained by most states, paid through employers' workers' compensation insurance premiums, in the hope that the outcome will encourage employers to hire the handicapped or previously injured workers. The employer's compensation carrier makes payments for the second injury, and the fund reimburses the carrier for any additional costs.

D. Apportionment

Apportionment is a legal device for distributing financial responsibility to the insured employer versus previous employers, or the worker him/herself. It is intended to ensure that employers are only responsible for the portion of injuries or illnesses that actually were caused in their workplace. Apportionment applies only to permanent disability.

Diagnostic assessment of causation must sometimes address the medicolegal question of apportionment. The compensability of a claim of occupational illness or injury is challenging in cases that involve multiple organ systems, or which present as a common symptom (eg, shortness of breath) which overlaps with many other common ailments or a preexisting condition, or which may be of a recurring nature (eg, asthma), or which could be caused or aggravated by both work-related and non-work-related factors that cannot be readily distinguished. Apportionment is an additional burden in the award of compensation, requiring the highest level of medical diagnostic skill and experience.

E. Compromise and Release

Compromise and release settlements are now accepted by workers' compensation for permanent disability in nearly all states. These settlements allow the payment of benefits in a lump sum, rather than a series of payments over longer periods of eligibility. The settlement represents a compromise on the part of the claimant and the insurer or employer, although the settlement is more likely to benefit the employer or insurer in the long run.

These agreements typically involve a partial or full release of the employer and insurer from further liability for the injury. Because the future course of disability and medical treatment cannot be predicted with certainty, such benefit payments and the termination of future liability may present unforeseen liability to the injured worker who has significant short-term financial needs associated with loss of employability and other impacts on his/her life. When the worker is induced to accept an immediate cash settlement, the incentive to have money in hand then blocks the benefits such as longer-term income maintenance and rehabilitation which are critical provisions of workers' compensation to which the worker is entitled.

F. Experience Rating

Workers' compensation benefits are funded by employers largely through insurance premiums. In a step of the rate-making process known as "experience rating," workers' compensation insurers compute a standard insurance premium rate for each industry group (eg, SIC or NAICS code) annually as a dollar amount per \$100 of payroll. The rate for an individual employer may be above or below the standard rate. The assessment rate for firms with better than average safety records is reduced, and the rates of firms with worse than average safety records are increased.

In theory, experience rating encourages employers to promote safety in the workplace, since fewer injuries result in lower insurance premiums. Experience rating assumes that industry and its insurers respond to financial incentives to provide cost-effective programs. Workers' compensation insurers argue that if the system were to be replaced, costs of coverage would be subject to the same rating system that applies to other health insurance. The insurance industry often uses experience rating to demonstrate their commitment to workplace safety. In actual fact, only the large employers are experience-rated. Small employers are typically insured in groups of similar companies. As the definitions of compensable injury are broadened, the intent and benefits of experience rating are diluted.

ROLE OF THE PHYSICIAN

Workers' compensation laws place the treating physician in a critically important role. The physician serves as the gatekeeper to benefits in the workers' compensation system, a health care system that is separate from mainstream medicine. Physicians must determine that an injury or illness is caused by work, diagnose it, prescribe care, and assess the extent of impairment and the ability of the worker to resume work.

Most physicians who participate in the workers' compensation system do not require specialized training in the diagnosis or treatment of occupational injuries, diseases, and related areas of disability. Most work injuries and diagnoses are related to acute trauma and are either self-limited or do not necessarily require specialized training to diagnose and treat them. Primary care for work injuries is predominantly provided by emergency rooms, clinics, and medical practices devoted to worker injuries and other forms of urgent care. Physicians must demonstrate a willingness to accept workers' compensation insurance rates, which are typically set at parity or below Medicare. Orthopedic surgeons play a prominent role in workers' compensation because of the large number of musculoskeletal injuries. Residency-trained occupational medicine specialists ("occupational physicians") actually play a relatively small role in workers' compensation injury care, as their training and specialization is focused more on occupational disease and cumulative

trauma disorders where skills in history taking, exposure assessment, differential diagnosis and causation assessment are required.

Determinations that injuries or illnesses are caused by work are increasingly contentious. The physician who takes a careful occupational health history, documenting the details of the events leading up to and including the event of the injury or illness, often will be the most important influence on the finder of fact (workers' compensation judge or referee) as to work-relatedness. The physician who provides treatment and follows the worker medically usually will be the most important influence on the finder of fact as to the nature and extent of the injury or illness.

All parties—the worker, the employer, and the insurer—benefit from an emphasis by the treating physician on early return to work. The proper determination of work restrictions acceptable to the employer and the worker draws on the physician's experience, his or her familiarity with the workplace and job description, and his or her rapport with both the worker and the employer. Moreover, through continuing care of the worker, the physician determines when the worker has reached maximal medical improvement (MMI) or maximal functional recovery (MFR).

Insurers also may ask the physician to determine work restrictions (eg, no overhead lifting for someone with shoulder problems or no working around moving machinery or at unprotected heights for someone with a balance problem) in order to match the impairment to specific jobs. In some instances, the exact physical restrictions are best determined by a functional-capacity evaluation. There are growing numbers of specialized centers that can assist physicians with both detailed job analyses and functional-capacity evaluations.

► Physician Selection

Workers in many states are permitted by state workers' compensation regulations to choose their own physicians. The choice may be any licensed physician or may be made from a list maintained by the employer or the state workers' compensation agency. The selection criteria for physician competence, qualifications, and experience vary with the jurisdiction.

The worker must submit to periodic examinations by a physician of the employer's choice. If either the employer or the worker is dissatisfied with the progress under the chosen physician's treatment, either party can request, and often is allowed, to change physicians. Typically, an employee is permitted one such change for subjective reasons alone. In contrast, the employer can be required to prove to the state agency that a change is needed. Reasons for discharging a physician include incompetence, lack of reasonable progress toward recovery, inadequate or insufficient reporting by the physician, and inconvenience of the physician's practice location.

If the employer selects the physician, if the injured employee is not satisfied with the treatment and progress, he/she may be permitted consultation with another physician at the employer's (insurer's) expense.

Although the employer must cover the cost of medical treatment for the injured employee, if the employee refuses reasonable treatment or surgery without justifiable cause, the employer is relieved of responsibility for any benefits related to injuries caused by the delay in or refusal of any treatment. When the suggested treatment or surgery entails a significant risk, the worker's refusal usually is considered justified.

► Disability Determinations

About 15–20% of people aged 45–64 have work disabilities, defined as limitations in their ability to work. Insurers in many states ask the physician to determine the degree of “impairment” (measured by anatomic or functional loss), which the insurers will give to disability raters, workers' compensation judges, commissioners, or hearing officers. These nonmedical people make the decision as to “disability” and to the degree of disability and its level of compensation. Disability, unlike impairment, depends on the job and one's ability to compete in the open job market. Impairment does not necessarily imply disability. For example, the loss of the distal phalanx of the second digit on the left hand results in the same impairment rating in a concert violinist and in a roofer, but the disability is much greater for the musician. It is important to discuss impairment and disability separately. An individual with carpal tunnel syndrome may be disabled when considered for a job with repetitive hand movements but not for a job that does not require extensive use of the hands.

In some states, an independent “rating physician” designated by the state workers' compensation governing agency examines the claimant to provide this determination. In other states, the treating physician examines and documents the injured worker's “objective” impairments, and a government administrator or tribunal makes the actual determination of the percentage of PPD. In many states, rating physicians include chiropractors. Fees for disability evaluations are often fixed by statute. Formal training for physicians who provide impairment and disability evaluations is offered by the American Board of Independent Medical Examiners (ABIME) and the American Academy of Disability Evaluating Physicians (AADEP).

Few physicians recognize their individual pivotal role in preventing the broad economic consequences of occupational disability. The AMA's *Guides to the Evaluation of Permanent Impairment* is increasingly accepted as a standard for impairment and disability assessment in the United States by both state and federal programs. The AMA *Guides* emphasizes the fundamental skills physicians need

to evaluate and communicate patient impairments. The sixth edition applies both terminology from and an analytical framework based on the International Classification of Functioning, Disability and Health (ICF), to generate five impairment classes which permit the rating of the patient from “no impairment” to “most severe.”

Many workers’ compensation cases are settled with “continuing medical treatment” provided either within limits or as a lifelong benefit. The opinion as to the value of continued medical treatment and for what purpose it is to be rendered should be stated, along with recommendations for current treatment should it be different from treatment already given the employee by other physicians.

► Compensable Occupational Diseases

Occupational diseases affect 15–20% of all workers. Conservative estimates are that 6–10% of cancers, and 5–10% of myocardial infarctions, strokes, and transient ischemia are caused by workplace factors. Occupational neurological, psychological, renal, and many other diseases are not even estimated because data are so limited, and so few studies are funded. The majority of individuals with known or suspected occupational disease do not file claims for workers’ compensation benefits. Workers who develop occupational diseases following long latency periods seldom receive the benefits to which they are entitled.

Many states have rewritten their workers’ compensation laws, making it even more difficult for injured workers to receive compensation. A primary interest of state legislatures is to reduce employer costs by limiting worker access to benefits. As an example, states have passed major amendments to workers’ compensation laws to reduce benefits by placing limits on compensability. These restrictions included limiting the compensability of two conditions potentially likely to incur large treatment costs, repetitive trauma disorders and mental disabilities. Injuries caused by repetitive trauma, such as carpal tunnel syndrome and noise-induced hearing loss, were restricted by procedural and evidentiary changes that made it more difficult to prove compensability.

Moreover, many states now exclude availability of benefits for occupational stress claims. Fifteen states have simply ruled that stress claims are not compensable unless they are accompanied by a physical injury. Other states exclude stress claims when they are related to personnel actions, or they limit their consideration of claims to situations involving extraordinary or unusual circumstances. The burden of proof for these claims may require that employment be the predominant cause of injury or that claims be proved by a preponderance of evidence. Other amendments limit compensation for the aggravation of preexisting conditions or conditions related to aging.

Workers who develop occupational diseases following long latency periods often have their claims disputed by

employers and insurers, and seldom receive the benefits to which they are entitled. Similar problems exist for occupational asthma and related airway disorders. Fewer than one in a hundred occupational cancer claims ever receive workers’ compensation benefits. Claims for cancer made by smokers are especially contentious.

► Independent Medical Examiner

When a compensation claim determination is contested by the insurer, employer, or employee, physicians become important witnesses in resolving disputes. When a non-treating physician is requested to evaluate the worker, in most states this evaluation is designated as an independent medical examination (IME). Most requests for IME opinions come from insurers, but on occasion, plaintiffs’ attorneys, judges, and others may initiate an IME evaluation, and typically require the insurer to cover its cost. The opinion of the IME likely will be the final opinion for the worker and determine the success or failure of his or her claim. The IME does not establish a legal doctor-patient relationship because the examination of the worker is not based on the worker’s consent. The IME report should be complete and definitive and include diagnosis, cause of injury or illness, prognosis, maximal medical improvement status, permanent impairment, work capacity, and opinion on further clinical management. The IME physician must be prepared to testify at a deposition and, on rare occasion, appear before a workers’ compensation judge or referee. The IME physician seldom sees the worker again and ethically should not assume any responsibility for medical care. It is widely believed that IMEs predominantly provide opinions favorable to the defense (lawyers, insurers, and employers). Physicians should strive to be unbiased, despite the presence of some perverse incentives.

EMPLOYERS’ RESPONSIBILITIES

Workers’ compensation insurance coverage is compulsory for most private employment. Workers’ compensation laws cover approximately 87% of all wage and salary workers. Employees most likely to be exempt from coverage include self-employed people, domestic workers, agricultural workers, and casual laborers. Coverage also may be limited for workers in small companies with only a few employees, non-profit institutions, and state and local governments.

A. Demonstration of Ability to Pay Benefits

Unless exempted by the law, employers must demonstrate their ability to pay workers’ compensation benefits. There are three ways of accomplishing this: (1) insurance with a state fund, (2) insurance through a private carrier, or (3) self-insurance.

1. State insurance funds—The states have adopted two methods of meeting the problem of workers’ compensation coverage.

Some states require that employers insure through a state fund that operates as the exclusive provider of insurance. Other states operate their funds in competition with private carriers. A few states do not permit an employer to be self-insured.

2. Private insurance carriers—Private workers' compensation insurance contracts have two purposes: (1) to satisfy the employer's obligation to pay compensation and (2) to ensure that the injured employee receives all the benefits provided by law. A contracted insurer is responsible for compensating the injured worker, and generally the employer is not involved in any claims administration, except to the extent of modified duty and return to work issues. The carrier's liability is not relieved by either the insolvency or death of the employer or any disagreement the carrier may have with the employer. Most state funds are similarly restricted.

3. Self-insurance—Larger employers, or groups of smaller employers in a common industry, may decide to serve as their own insurers. This approach includes the responsibility for adjusting claims and paying benefits. These tasks are contracted out to companies that provide such services (ie, third-party administrators). To qualify as a self-insurer, a company or group of companies must demonstrate that it has the financial ability to pay all claims that reasonably may be expected. The state agency usually has specific requirements that a bond or other security be posted. Because this form of insurance is both time-consuming and requires financial reserves, smaller companies seldom self-insure.

Companies choose to self-fund to reduce costs and to maximize cash flows. Because costs of benefits, claim reserves, litigation, and attendant administrative costs have spiraled in recent years, many companies have concluded that they could do as well as independent carriers while saving the cost of commissions and premium taxes and take advantage of greater cash flow and increased investment income rates.

B. Penalties for Not Having Insurance

Workers' compensation insurance is mandatory in every state but Texas. There are heavy penalties for uninsured employers. They can be subject to fines, loss of common-law defenses, increases in the amount of benefits awarded, and payment of attorneys' fees. The biggest financial deterrent is that the employee may bring a civil suit against the employer. A number of states will force closure of an uninsured business. All states have an uninsured employer's fund(s) to which injured employees can apply for benefits. Applying to such a fund does not preclude the individual from also bringing legal action against the employer for penalties and legal fees. The uninsured employer is also

required to reimburse the fund for benefits paid to injured workers.

► Claim Filing Requirements

The injured or ill employee is required to report the injury or illness as soon as he or she becomes aware that it has occurred. For overt accidents, this requirement is straightforward, whereas for cumulative injuries or diseases, a correct diagnosis may be delayed, the problem may be misdiagnosed, or may not be readily attributable to a work-related cause.

A statute of limitations limits the employer's liability when an injury or illness is not reported within a week. The claim itself requires a written "notice of injury" in nearly all states. Employees who verbally inform their employer of a possible injury but do not put it in writing are thus vulnerable to loss of compensation benefits. In some states, the requirement is met if the employer is informed by someone other than the injured worker. Once a notice of injury has been filed, the employer then must provide all medical care reasonably required to alleviate the problem. If a claim is later denied by an insurer, there may develop a financial liability for the injured worker and/or physician for the care rendered in all but emergency situations.

In most states, there are no statutory limitations on the length of time for or the cost of treatment, although states and private insurers are implementing a number of cost-containment strategies. These include (1) utilization review of inpatient and outpatient care, (2) hospital bill auditing of inpatient services, (3) medical bill auditing of practitioner and other services, and (4) preferred-provider networks for inpatient care where fees are discounted, and outpatient care where the emphasis is on optimization of outcome measures. Most state laws allow for treatment even when recovery is not possible, that is, palliative care that does not cure but only relieves.

► Claims Disputes

Differences of opinion often arise over workers' compensation claims. Such disputes often result from issues of insurance coverage, work-relatedness of the injury or illness, provision of medical treatment, the worker's earnings capacity, and the extent of the disability. The latter is the most common cause of disputes and requires the physician to provide a formal medical opinion. Although the system was designed to be "no fault," a large number of claims are subject to disputes between the employer, the insurance carrier, and the worker. Because adjudication is cumbersome, costly, and time-consuming, tribunals are established to hear claims disputes in the minimum time possible and at the least cost.

In most states, the initiation of a claim is made by the worker, and the initial review is by the insurer. When there

is a disagreement on the result, either party can apply for a hearing before the workers' compensation agency or court. If there is still dissatisfaction with the hearing officer's decision, an appeal can be made.

The states vary widely in their methods of hearing disputes, but the most commonly used methods are (1) a court-administered system, (2) a wholly administrative system, and (3) a combination of the two. The last is rapidly becoming almost as unwieldy as the common-law approach that it was designed to replace.

A. The Court-Administered System

In the court-administered system, the employer may be covered either by an insurance carrier or by self-insurance. All injuries or illnesses resulting in more than 6 days of disability must be reported within 14 days, usually accompanied by a physician's report. (Time periods, exact procedures, fee percentages, and so on are drawn from one state for the purposes of example.) The state department of labor, through its workers' compensation division, decides whether the worker should receive compensation other than medical treatment. A form letter then is sent to the worker informing the worker of his or her rights in case additional benefits are decided on. Unless there is a complaint, the compensation agency takes no further action to ensure prompt payment, but the carrier must file notice when the claim is first paid. The system also requires that a settlement agreement be filed, even if the worker refuses to sign it. An administrative trial court reviews that agreement to determine whether the worker is receiving his or her just benefits. If so, the agreement is approved, and payments are made accordingly.

The employer has 10 days thereafter to file with the division certified copies of all relevant documents from the worker's file. If the division decides that the agreement does not provide sufficient benefits to the worker, the insurance carrier is required to adjust the agreement and have the court order modified. If the carrier refuses, the division advises the worker to take court action. Once the court has approved the settlement, it is binding on all parties if not contested within 30 days. However, the worker may go to trial court to contest the settlement at any time within 1 year of the injury. Compensation cases receive priority and usually are completed within 10 weeks. The case is heard by a trial judge and may be appealed to a civil court and from there even to the state supreme court if the judge's finding is unacceptable to the worker. The attorney may receive a set percentage of the award for his or her services.

B. The Wholly Administrative System

Under a wholly administrative system, the workers' compensation board reviews claims made against covered employers.

Injuries must be reported as soon as possible, and a claims adjudicator of a board located closest to the worker's home (again, using one state's system as an example) determines benefits or the denial of benefits. If the claim is denied, the worker is informed of the reason for denial and the procedure to appeal. Either the government, without charge, or the worker's union assists in the appeal. Judgments can be appealed, in turn, to a board of review in all cases except those related to a rehabilitation decision.

The review boards are part of the state department of labor but are totally disassociated from the workers' compensation division. In this example state, the review boards are composed of a chairperson and two members, one chosen by an employers' group and the other by an organization of workers.

The claimant must make an appeal within 90 days after the claims adjudicator's report has been received. The appeal may be in the form of a letter stating the claimant's objections, or it may be submitted on a two-page form used for that purpose. The review board studies the workers' compensation board file and any new information the board obtains in the course of its decision making. There is no hearing on the matter unless the claimant requests it, and such a request will be denied if the board decides that an appeal is not justified. If the board agrees to a hearing, it is held at a location that is convenient for the worker. The worker may have an attorney, but the appeals process does not include payment of the attorney's fees, that being the responsibility of the worker.

Although the decision of the review board is usually binding, it can be appealed further to the commissioners of the workers' compensation board within 60 days by a labor union on behalf of the injured worker or by an organization of employers on behalf of the injured worker or employer. If the chairperson of the review board believes that an important principle underlies the appeal, he or she may allow the worker to make an appeal within 30 days. Furthermore, if the decision of the review board is not unanimous, the worker is permitted to appeal to the commissioners on his or her own behalf within 60 days. The decision of the commissioners is binding and may not be appealed to the courts.

A medical review panel exists for medical issues only. This panel is composed of a chairperson appointed by the government and two physicians, one selected by the worker and one by the employer. Decisions by this panel are final. Many states sponsor less formal panels of physicians who interview and examine the claimant and then render opinions on disability, work restrictions, treatment, and prognosis.

C. The Combination System

The workers' compensation agency under the combination system is composed of a seven-member appeals board that is

responsible only for reviewing appeals and an administrative director who is responsible for the administrative functions of the agency. In California, for example, eight individuals are appointed by the governor and confirmed by the state senate.

Both the employer and the attending physician (again, using one state's system as an example) must file reports of worker injury or illness with the state division of labor statistics and research. They are usually submitted through the employer's compensation carrier or adjusting agent, and constitute the initiation of a claim. Furthermore, within 5 days of the injury, the employer must inform the injured worker, in simple terms, not only about the benefits to which he or she is entitled but also about the services available from the state division of workers' compensation. The employer is further required to inform the compensation system administrator, as well as the worker, about commencement and termination dates of benefits, nonpayment of benefits, and rejection of claims. The worker also must be informed that he or she can obtain an attorney, if desired. The worker further must be advised that any action must be taken promptly to avoid loss of compensation.

Thus the worker is informed of his or her rights, and because there are penalties for the unwarranted rejection of compensation, many claims are paid automatically. The division of workers' compensation becomes involved only if either the employer or the employee seeks adjudication from the workers' compensation appeals board. Such adjudication is initiated by the filing of a simple one-page form. The application must be filed within 1 year of the injury or by the date of the termination of benefits, whichever is longer. If the adjudication claim is related to further trauma resulting from the original injury, the application requirement is 5 years from the date of the original injury.

Although the system anticipates that a hearing will be held within 30 days of the application, this is seldom possible because of backlog. The hearings are conducted at several locations throughout the state and are assigned to a workers' compensation judge who makes the decision. Each judge usually reviews approximately 90 cases per month.

The hearings are designed to be informal, but often they cannot be distinguished from a nonjury court trial. The judges are knowledgeable in the workers' compensation process and are required to develop additional information if the evidence provided by the parties is inadequate—but they are not medical professionals, nor are they required to have any medical or scientific training. Medical information usually is presented in written reports. Once all the evidence is presented, the judge must present a written decision within 30 days.

If the employer or the employee is dissatisfied with the decision, an appeal can be filed. This appeal is sometimes called a *petition for reconsideration* and must be filed within

20 days of the posting of the original decision. It is heard by a panel of three members of the appeals board. The panel is authorized to approve or deny reconsideration, issue a different decision based on the original evidence, or seek additional information, including consultation with an independent medical specialist.

The decision of this panel is final unless the dissatisfied party seeks a review within 45 days by submitting a petition for a writ of review to the appeals court. The court is empowered to deny the review without explanation. If a review is permitted, the appeals court studies the evidence, hears oral arguments, and presents a written decision. If the party bringing the appeal is still dissatisfied, that party may petition the state supreme court for a further hearing. However, state supreme courts rarely accept more than a few workers' compensation cases each year and only accept cases that contain precedent-setting issues.

In the most contested cases, both parties are represented either by attorneys or by expert lay representatives. On average, those representing the worker receive 9–15% of the award.

▶ Reopening of Claims

Workers' compensation proceedings differ from civil lawsuits in one important aspect—the body that originally decided the award may alter its decision if the worker's condition changes or if there is other reasonable cause. This process may be limited under certain conditions by state compensation laws, and most states establish a time limit beyond which a modification cannot be made. If the requirements of the law cannot be met, final decisions in compensating cases are as binding as those in any judicial proceeding.

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■ SELF-ASSESSMENT QUESTIONS

Select the one correct answer to each question.

Question 1: Workers' compensation law

- a. is intended primarily to assign liability
- b. existed in the United States before European countries followed suit
- c. was first enacted by the states, then the Federal government
- d. requires the employer to provide compensation benefits to the injured employee

Question 2: Workers' compensation systems

- a. avoid lengthy and costly legal action
- b. provide an injured employee with medical treatment only when the incident is the fault of the employer
- c. compensate work injuries that activate or aggravate a preexisting condition
- d. do not compensate earlier compensable injury

Question 3: Occupational injuries

- a. are mostly temporary disability cases
- b. occur in fewer than 1 million workers each year in the United States
- c. are defined as injuries that involve time away from work
- d. are being erased through modern technology

Question 4: Temporary total disability

- a. encompasses the majority of occupational injuries
- b. benefits are paid during the recovery period on the basis of the worker's average earnings
- c. entails a waiting period, but it is paid retroactively if the worker cannot work for a certain number of days or if hospitalization is necessary
- d. is the most costly category of workers' compensation benefits

Question 5: Permanent total disability

- a. occurs in more than 10% of all compensable workers' compensation claims
- b. covers those workers who are so disabled that they will never be able to work again in an open labor market and for whom further treatment offers no hope of recovery

- c. in most states is compensated with half of the workers' average wages
- d. does not provide additional funds for dependents

Question 6: Experience rating

- a. applies to all employers regardless of size
- b. is responsible for all injury costs to decline in recent years
- c. results in major workers' compensation savings for small firms
- d. applies to large employers

Question 7: Impairment

- a. is seldom determined by the physician
- b. is measured by anatomic or functional loss
- c. is another term for disability
- d. depends on the job and one's ability to compete in the open job market

Question 8: Occupational disease

- a. is present in half of all Americans
- b. claims result in benefits for most all workers with delayed illnesses
- c. claims in many states face limits on compensability
- d. does not include repetitive trauma disorders and mental disabilities

Question 9: Apportionment

- a. is a legal device for determining probable cause
- b. is intended to ensure that employers are responsible for all injuries or illnesses
- c. applies only to permanent disability
- d. no longer determines financial responsibility

Question 10: Compromise and release settlements

- a. are accepted by workers' compensation in only a few states
- b. allow the payment of benefits in a lump sum, rather than a series of payments over longer periods of eligibility
- c. represent a compromise only on the part of the insurer or employer
- d. are more likely to benefit the applicant than the employer