



DWC 15th Annual Educational Conference

Return to Work

Presenters

Otis Byrd
Sandra Cortes

Los Angeles Sheraton February 28-29, 2008
Oakland Marriot March 3-4, 2008

RETRAINING & RETURN TO WORK

Presented

By

Otis Byrd and Sandra Cortes

*Documenting
Permanent Disability*

- Findings & Award (F&A)
- Stipulated F&A
- Compromise & Release (C&R) with PD reference
- C& R without PD reference



2. *Do's*:

- Use Vocational Return to Work Counselor (VRTWC)
- Use Approved Training Schools



3. *Do not's:*

- Fail to reimburse injured or pay training school due to arbitrary reasons
- Require progress reports
- Require installment payments



4. *Maybe:*

- *Voucher can be settled within Compromise and Release Agreement ONLY*

BPPVE Replacement:

- US Dept. of Education Office of Post Secondary Education

<http://www.ope.ed.gov/accrditation/search.asp>

- State Agency (Memorandum of Understanding) approved Training





- Out-of-state Training
- Western Association of Schools and Colleges Accreditation

Becoming a VRTWC:

- The minimum qualifications
- Application with supporting documentation



Being on the List:

- Fees can be charged for services rendered up to 10% of voucher. (There is no fee schedule for DOI's post 1/1/04)
- Web List updated/reviewed at least annually

http://www.dir.ca.gov/dwc/SJDBN/RTWC_list.pdf



Removal from List:

- Request of VRTWC
- Unavailability
- Falsification of application



IV. Worksite Accommodation

Issues regarding

Approval:

- Requests for non-injured workers
- Incomplete DWC-AD 10005
- Lack of substantiating documentation





- Failure to provide RTW strategy pursuant to LC and/or Regulations
- Referring injured employee to training in which VRTWC has proprietary relationship

Approval Issues:

- Requests for “non-injured” employees
- Incomplete DWC-AD 10005
- Lack of substantiating documentation (e.g. receipts, medical report, itemized list of costs)





- Missing California STD 204-Payee Data Record Form

- Missing DWC-AD 10133.53



Trends:

- Accounting approval
- Statistics
- The bigger picture

TITLE 8. INDUSTRIAL RELATIONS

DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION SUBCHAPTER 1.5. INJURIES ON OR AFTER JANUARY 1, 1990 ARTICLE 7.5. SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

§ 10133.50. Definitions

(a) The following definitions apply for injuries occurring on or after January 1, 2004:

(1) Alternative Work. Work that the employee has the ability to perform, that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and that is located within reasonable commuting distance of the employee's residence at the time of injury.

(2) Approved Training Facility. A training or skills enhancement facility or institution that meets the requirements of section 10133.58.

(3) Claims Administrator. The person or entity responsible for the payment of compensation for a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) Employer. The person or entity that employed the injured employee at the time of injury.

(5) Essential Functions. Job duties considered crucial to the employment position held or desired by the employee. Functions may be considered essential because the position exists to perform the function, the function requires specialized expertise, serious results may occur if the function is not performed, other employees are not available to perform the function or the function occurs at peak periods and the employer cannot reorganize the work flow.

(6) Insurer. Has the same meaning as in [Labor Code section 3211](#).

(7) Modified Work. Regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(8) Nontransferable Training Voucher. A document provided to an employee that allows the employee to enroll in education-related training or skills enhancement. The document

shall include identifying information for the employee and claims administrator, specific information regarding the value of the voucher pursuant to [Labor Code section 4658.5](#).

(9) Notice. A required letter or form generated by the claims administrator and directed to the injured employee.

(10) Offer of Modified or Alternative Work. An offer to the injured employee of medically appropriate employment with the date-of-injury employer in a form and manner prescribed by the Administrative Director.

(11) Parties. The employee, the claims administrator and their designated representatives, if any.

(12) Permanent Partial Disability Award. A final award of permanent partial disability determined by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

(13) Regular Work. The employee's usual occupation or the position in which the employee was engaged at the time of injury and that offers wages and compensation equivalent to those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(14) Supplemental Job Displacement Benefit. An educational retraining or skills enhancement allowance for injured employees whose employers are unable to provide work consistent with the requirements of [Labor Code section 4658.6](#).

(15) Vocational & Return to Work Counselor (VRTWC). A person or entity capable of assisting a person with a disability with development of a return to work strategy and whose regular duties involve the evaluation, counseling and placement of disabled persons. A VRTWC must have at least an undergraduate degree in any field and three or more years full time experience in conducting vocational evaluations, counseling and placement of disabled adults.

(16) Work Restrictions. Permanent medical limitations on employment activity established by the treating physician, Qualified Medical Examiner or Agreed Medical Examiner.

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Sections 124, 4658.1, 4658.5 and 4658.6, Labor Code](#).

§ 10133.51. Notice of Potential Right to Supplemental Job Displacement Benefit

(a) This section and section 10133.52 shall only apply to injuries occurring on or after January 1, 2004.

(b) Within 10 days of the last payment of temporary disability, if not previously provided, the claims administrator shall send the employee, by certified mail, the mandatory form "Notice of Potential Right to Supplemental Job Displacement Benefit Form" that is set forth in Section 10133.52.

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Section 4658.5, Labor Code](#).

§ 10133.52. "Notice of Potential Right to Supplemental Job Displacement Benefit Form."

Notice of Potential Right to Supplemental Job
Displacement Benefit Form
(Mandatory Form)

If your injury causes permanent partial disability, which prevented you from returning to work within 60 days of the last payment of temporary disability, and the claims administrator has not provided you with a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work," you may be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools.

The amount of the voucher for the supplemental job displacement benefit will be as follows:

Up to four thousand dollars (\$ 4,000) for a permanent partial disability award of less than 15%.

Up to six thousand dollars (\$ 6,000) for a permanent partial disability award between 15 and 25%.

Up to eight thousand dollars (\$ 8,000) for a permanent partial disability award between 26 and 49%.

Up to ten thousand dollars (\$ 10,000) for a permanent partial disability award between 50 and 99%.

A permanent partial disability award is issued by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board. You may also settle your potential eligibility for a voucher as part of a compromise and release settlement for a lump sum payment. Any settlement must be reviewed and approved by a Workers' Compensation Administrative Law Judge.

The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. Not more than 10 percent of

the voucher moneys may be used for vocational or return to work counseling. A list of vocational return to work counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request.

If you are eligible, and you have not already settled the benefit, you will receive the voucher from the claims administrator within 25 calendar days from the date the permanent partial disability award is issued by the Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

If modified or alternative work is available, you will receive a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work" from the claims administrator within 30 days of the termination of temporary disability indemnity payments. The claims administrator will not be required to pay for supplemental job displacement benefits if the offer for modified or alternative work meets the following conditions:

- (1) You have the ability to perform the essential functions of the job provided;
- (2) the job provided is in a regular position lasting at least 12 months;
- (3) the job provided offers wages and compensation that are at least 85 percent of those paid to you at the time of the injury; and
- (4) the job is located within reasonable commuting distance of your residence at the time of injury.

If there is a dispute regarding the Supplemental Job Displacement Benefit, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

If you have a question or need more information, you can contact your employer or the claims administrator listed below. You can also contact a State Division of Workers' Compensation Information and Assistance Officer.

Date: ...
Name of Claims Administrator:Phone No.: ...
Address of Claims Administrator:
Email (optional):

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Section 4658.5, Labor Code](#).

§ 10133.53. Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work."

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

[See Illustration In Original Printed Version]

Note: Authority cited: [Sections 133, 4658 and 5307.3, Labor Code](#). Reference: [Sections 4658, 4658.1, 4658.5 and 4658.6, Labor Code](#).

§ 10133.54. Dispute Resolution

(a) This section and section 10133.55 shall only apply to injuries occurring on or after January 1, 2004.

(b) When there is a dispute regarding the Supplemental Job Displacement Benefit, the employee, or claims administrator may request the Administrative Director to resolve the dispute.

(c) The party requesting the Administrative Director to resolve the dispute shall:

(1) Complete Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director;"

(2) Clearly state the issue(s) and identify supporting information for each issue and position;

(3) Attach all pertinent documents;

(4) Submit the original request and all attached documents to the Administrative Director and serve a copy of the request and all attached documents on all parties; and

(5) Sign and date the proof of service section of Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

(d) The opposing party shall have twenty (20) calendar days from the date of the proof of service of the Request to submit the original response and all attached documents to the Administrative Director and serve a copy of the response and all attached documents on all parties.

(e) The Administrative Director or his or her designee may request additional information from the parties.

(f) The Administrative Director or his or her designee shall issue a written determination and order based solely on the request, response, and any attached documents within thirty

(30) calendar days of the date the opposing party's response and supporting information is due. If the Administrative Director or his or her designee requests additional information, the written determination shall be issued within thirty (30) calendar days from the receipt of the additional information. In the event no decision is issued within sixty (60) calendar days of the date the opposing party's response is due or within sixty (60) calendar days of the Administrative Director's receipt of the requested additional information, whichever is later, the request shall be deemed to be denied.

(g) Either party may appeal the determination and order of the Administrative Director by filing a written petition together with a Declaration of Readiness to Proceed pursuant to section 10414 with the local district office of the Workers' Compensation Appeals Board within twenty calendar days of the issuance of the decision or within twenty days after a request is deemed denied pursuant to subdivision (f). The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and a copy of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Sections 4658.5 and 4658.6, Labor Code](#).

§ 10133.55. Form DWC-AD 10133.55 "Request for Dispute Resolution Before the Administrative Director."

[See Illustration In Original Printed Version]

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Section 4658.5, Labor Code](#).

§ 10133.56. Requirement to Issue Supplemental Job Displacement Nontransferable Training Voucher

(a) This section and section 10133.57 shall only apply to injuries occurring on or after January 1, 2004.

(b) The employee shall be eligible for the Supplemental Job Displacement Benefit when:

(1) the injury causes permanent partial disability; and

(2) within 30 days of the termination of temporary disability indemnity payments, the claims administrator does not offer modified or alternative work in accordance with [Labor Code section 4658.6](#); and

(3) either the injured employee does not return to work for the employer within 60 days of the termination of temporary disability benefits; or

(4) in the case of a seasonal employee, where the employee is unable to return to work within 60 days of the termination of temporary disability benefits because the work season has ended, the injured employee does not return to work on the next available work date of the next work season.

(c) When the requirements under subdivision (b) have been met, the claims administrator shall provide a nontransferable voucher for education-related retraining or skill enhancement or both to the employee within 25 calendar days from the issuance of the permanent partial disability award by the Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

(d) The voucher shall be issued to the employee allowing direct reimbursement to the employee upon the employee's presentation to the claims administrator of documentation and receipts or as a direct payment to the provider of the education related training or skill enhancement and/or to the VRTWC.

(e) The voucher must indicate the appropriate level of money available to the employee in compliance with [Labor Code section 4658.5](#).

(f) The mandatory voucher form is set forth in Section 10133.57.

(g) The voucher shall certify that the school is approved and if outside of California, approval is required similarly to the Bureau for Private Postsecondary (BPPVE).

(h) The claims administrator shall issue the reimbursement payments to the employee or direct payments to the VRTWC and the training providers within 45 calendar days from receipt of the completed voucher, receipts and documentation.

Note: Authority cited: [Sections 133, 4658.5, 4658.6 and 5307.3, Labor Code](#). Reference: [Sections 4658.5 and 4658.6, Labor Code](#).

§ 10133.57. Form DWC-AD 10133.57 "Supplemental Job Displacement Nontransferable Training Voucher Form."

Supplemental Job Displacement Nontransferable
Training Voucher Form
(Form DWC-AD 10133.57 -- Mandatory Form)
For injuries occurring on or after 1/1/04

You have been determined eligible for this nontransferable, Supplemental Job Displacement Voucher. This voucher may be used for the payment of tuition, fees, books,

and other expenses required by a state approved or accredited school that you enroll in for the purpose of education related retraining or skill enhancement, or both.

The state approved or accredited school will be reimbursed upon receipt of a documented invoice for tuition, fees, books and other required expenses required by the school for retraining or skill enhancement. If you pay for the eligible expenses, you may be reimbursed for these expenses upon submission of documented receipts. No more than 10 percent of the value of this voucher may be used for vocational or return to work counseling. If you decide to voluntarily withdraw from a program, you may not be entitled to a full refund of the voucher amount utilized.

Please present this original letter to the state approved or accredited school and/or the Vocational & Return to Work Counselor of your choice, chosen from the list developed by the Division of Workers' Compensation's Administrative Director, in order to initiate your training and return to work counseling. A list of Vocational & Return to Work Counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request. The school and/or counselor should contact me regarding direct payment from your supplemental job displacement benefit.

Injured Employee Information: Upon completing the voucher form the injured employee must return the form with receipts and documentation to the claims administrator immediately for reimbursement. (The claims administrator must complete Nos. 1-8 of this voucher form prior to sending it to the injured employee.)

1. Injured Employee Name ...
2. AddressCity ...State ... Zip Code...
3. Claim Number ...Phone Number ...

Claims Administrator

4. Name...
5. Claims Mailing Address ...
6. City ...State.....Zip Code ...
7. Claims Representative ...Phone Number.....
8. \$ is available to the injured employee based on% of Permanent Partial Disability Award

The injured employee must complete Nos. 9-19 and sign and date this voucher form.

(VRTWC) Vocational Return to Work Counselor (if any)

9. Name ...Phone Number.....

10. Address ...

11. City ...State..... Zip Code...

12. Funds used for vocational and return to work counseling \$ (10% maximum of voucher value)

Training Provider Details (Attach additional pages for each provider if necessary.)

13. Provider Name...

14. Provider Address ...Phone Number.....

15. City ...State..... Zip Code...

16. Provider approval number...

17. Expiration Date

18. Provider Contact Name ...

19. Training Cost

Injured Employee Signature ...Date...

Note to Claims Administrator: Upon receipt of voucher, receipts and documentation from the employee, reimbursement payments to the employee or direct payments to VRTWC and training providers must be made within 45 calendar days.

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Section 4658.5, Labor Code](#).

§ 10133.58. State Approved or Accredited Schools

(a) This section shall only apply to injuries occurring on or after January 1, 2004.

(b) Private providers of education-related retraining or skill enhancement selected to provide training as part of a supplemental job displacement benefit shall be:

(1) approved by the Bureau for Private Postsecondary and Vocational Education (www.bppve.ca.gov), or a California state agency that has an agreement with the Bureau for the regulation and oversight of non-degree-granting private postsecondary

institutions;

(2) accredited by one of the Regional Associations of Schools and Colleges authorized by the United States Department of Education; or

(3) certified by the Federal Aviation Administration.

(c) Any training outside of California must be approved by an agency in that state similar to the Bureau for Private Postsecondary and Vocational Education.

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Section 4658.5, Labor Code](#).

§ 10133.59. The Administrative Director's List of Vocational Return to Work Counselors

(a) This section shall only apply to injuries occurring on or after January 1, 2004.

(b) The Administrative Director shall maintain a list of Vocational & Return to Work Counselors (VRTWC) who perform the work of assisting injured employees. A VRTWC who meets the qualifications specified in Section 10133.50(a)(15) must apply to the Administrative Director to be included on the list throughout the year. The list shall be reviewed and revised on a yearly basis, and shall be made available on the website www.dir.ca.gov or upon request.

(c) The injured employee may select a Vocational & Return to Work Counselor whenever the assistance of a Vocational & Return to Work Counselor is needed to facilitate an employee's vocational training or return to work in connection with the Supplemental Job Displacement Benefit set forth in this Article.

(d) The injured employee shall be responsible for providing the VRTWC with any necessary medical reports. However, a claims administrator shall provide a VRTWC with any medical reports, including permanent and stationary medical reports, upon an employee's written request and a signed release waiver.

(e) The VRTWC shall communicate with the injured employee regarding the evaluation.

Note: Authority cited: [Sections 133, 4658.5 and 5307.3, Labor Code](#). Reference: [Section 4658.5, Labor Code](#).

§ 10133.60. Termination of Claims Administrator's Liability for the Supplemental Job Displacement Benefit

(a) For injuries occurring on or after January 1, 2004, the claims administrator's liability

to provide a supplemental job displacement voucher shall end if either (a)(1) or (a)(2) occur:

(1) the claims administrator offers modified or alternative work to the employee, meeting the requirements of [Labor Code §4658.6](#), on DWC-AD Form 10133.53 "Notice of Offer of Modified or Alternative Work";

(A) If the claims administrator offers modified or alternative work to the employee for 12 months of seasonal work, the offer shall meet the following requirements:

1. the employee was hired on a seasonal basis prior to injury; and
2. the offer of modified or alternative work is on a similar seasonal basis to the employee's previous employment;

(2) the maximum funds of the voucher have been exhausted.

Note: Authority cited: [Sections 133 and 5307.3, Labor Code](#). Reference: [Sections 4658.1, 4658.5, 4658.6 and 5410, Labor Code](#); and [Henry v. WCAB \(1998\) 68 Cal.App.4th 981](#).

DWC-AD 10133.55 Request for Dispute Resolution Before the Administrative Director (For injuries occurring on or after 1/1/04) ___ Original ___ Response		Has employer accepted this claim? ___ Yes ___ No Has liability for injury been found by the WCAB? ___ Yes ___ No Has it been more than 60 days since TTD ended? ___ Yes ___ No Has PPD award been stipulated, issued/approved? ___ Yes ___ No		DWC Use Only			
Social Security Number			WCAB Number		DWC Unit Number		
Employee Name (Last)		(First)		(MI)	Phone	Date of Birth	
Address (Street)		(City)		(State)		(Zip)	
Employer Name			Phone		Insurance Company Name; Or, if Self-Insured, Certificate Name		
Address			Adjusting Agency Name (if adjusted)				
City, State, Zip			Claims Mailing Address				
Date of Injury		Claim Number		City, State, Zip		Phone No.	
Employee Representative (if any)			Employer Representative				
Firm Name			Firm Name				
Address			Address				
City, State, Zip		Phone No.		City, State, Zip		Phone No.	
Vocational & Return to Work Counselor (if applicable)							
Firm Name			Representative Name				
Address (Street, City, State, Zip)					Phone No.		
The Administrative Director is requested to resolve the following dispute because the parties disagree on: (Please describe and attach all pertinent documents)							
Summary of Parties' Informal Efforts to Resolve this Dispute				Proof of Service: I declare under penalty of perjury under the laws of the State of California that on the date written below, I mailed a copy of this request with a copy of any documents included with this request to the following parties at the following addresses:			
				Administrative Director, (SJDB), Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603			
Name of Requester			Date		Signature		Date

TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE
RULES

ARTICLE 12

RETURN TO WORK

10001. Definitions.

As used in this Article:

(a) "Alternative work" means work (1) offered either by the employer who employed the injured worker at the time of injury, or by another employer where the previous employment was seasonal work, (2) that the employee has the ability to perform, (3) that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and (4) that is located within a reasonable commuting distance of the employee's residence at the time of injury.

(b) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(c) "Modified Work" means regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(d) "Permanent and stationary" means the point in time when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment, based on (1) an opinion from a treating physician, AME, or QME; (2) a judicial finding by a Workers' Compensation Administrative Law Judge, the Workers' Compensation Appeals Board, or a court; or (3) a stipulation that is approved by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

(e) "Regular Work" means the employee's usual occupation or the position in which the employee was engaged at the time of injury and that offers wages and compensation equivalent to those paid to the employee at the time of injury, and

located within a reasonable commuting distance of the employee's residence at the time of injury.

(f) "Seasonal Work" means employment as a daily hire, a project hire, or an annual season hire.

Authority: Sections 133, 139.48, and 5307.3, Labor Code.

Reference: Sections 139.48, and 4658.1, Labor Code; Henry v. WCAB (1998) 68 Cal.App.4th 981.

10002. Offer of Work; Adjustment of Permanent Disability Payments.

(a) This section shall apply to all injuries occurring on or after January 1, 2005, and to the following employers:

- (1) Insured employers who employed 50 or more employees at the time of the most recent policy inception or renewal date for the insurance policy that was in effect at the time of the employee's injury;
- (2) Self-insured employers who employed 50 or more employees at the time of the most recent filing by the employer of the Self-Insurer's Annual Report that was in effect at the time of the employee's injury; and
- (3) Legally uninsured employers who employed 50 or more employees at the time of injury.

(b) Within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary:

- (1) If an employer does not serve the employee with a notice of offer of regular work, modified work or alternative work for a period of at least 12 months, each payment of permanent partial disability remaining to be paid to the employee from the date of the end of the 60 day period shall be paid in accordance with Labor Code section 4658 (d)(1) and increased by 15 percent.
- (2) If an employer serves the employee with a notice of offer of regular work, modified work or alternative work for a period of at least 12 months, and in accordance with the requirements set forth in paragraphs (3) and (4), each payment of permanent partial disability remaining to be paid from the date the offer was served on the employee shall be paid in accordance with Labor

Code section 4658 (d)(1) and decreased by 15 percent, regardless of whether the employee accepts or rejects the offer.

(3) The employer shall use Form DWC-AD 10133.53 (Section 10133.53) to offer modified or alternative work, or Form DWC-AD 10003 (Section 10003) to offer regular work. The claims administrator may serve the offer of work on behalf of the employer.

(4) The regular, alternative, or modified work that is offered by the employer pursuant to paragraph (2) shall be located within a reasonable commuting distance of the employee's residence at the time of the injury, unless the employee waives this condition. This condition shall be deemed to be waived if the employee accepts the regular, modified, or alternative work, and does not object to the location within 20 calendar days of being informed of the right to object. The condition shall be conclusively deemed to be satisfied if the offered work is at the same location and the same shift as the employment at the time of injury.

(c) If the claims administrator relies upon a permanent and stationary date contained in a medical report prepared by the employee's treating physician, QME, or AME, but there is subsequently a dispute as to an employee's permanent and stationary status, and there has been a notice of offer of work served on the employee in accordance with subdivision (b), the claims administrator may withhold 15% from each payment of permanent partial disability remaining to be paid from the date the notice of offer was served on the employee until there has been a final judicial determination of the date that the employee is permanent and stationary pursuant to Labor Code section 4062.

(1) Where there is a final judicial determination that the employee is permanent and stationary on a date later than the date relied on by the employer in making its offer of work, the employee shall be reimbursed any amount withheld up to the date a new notice of offer of work is served on the employee pursuant to subdivision (b).

(2) Where there is a final judicial determination that the employee is not permanent and stationary, the employee shall be reimbursed any amount withheld up to the date of the determination.

(3) The claims administrator is not required to reimburse permanent partial disability benefit payments that have been withheld pursuant to this subdivision during any period for which the employee is entitled to temporary disability benefit payments.

(d) If the employee's regular work, modified work, or alternative work that has been offered by the employer pursuant to paragraph (1) of subdivision (b) and has been accepted by the employee, is terminated prior to the end of the period for which permanent partial disability benefits are due, the amount of each remaining permanent partial disability payment from the date of the termination shall be paid in accordance with Labor Code section 4658 (d) (1), as though no decrease in payments had been imposed, and increased by 15 percent. An employee who voluntarily terminates his or her regular work, modified work, or alternative work shall not be eligible for the 15 percent increase in permanent partial disability payments pursuant to this subdivision.

(e) Nothing in this section shall prevent the parties from settling or agreeing to commute the permanent disability benefits to which an employee may be entitled. However, if the permanent disability benefits are commuted by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board pursuant to Labor Code section 5100, the commuted sum shall account for any adjustment that would have been required by this section if payment had been made pursuant to Labor Code section 4658.

(f) When the employer offers regular, modified or alternative work to the employee that meets the conditions of this section and subsequently learns that the employee cannot lawfully perform regular, modified or alternative work, the employer is not required to provide the regular, modified or alternative work.

(g) If the employer offers regular, modified, or alternative seasonal work to the employee, the offer shall meet the following requirements:

- (1) the employee was hired for seasonal work prior to injury;
- (2) the offer of regular, modified or alternative seasonal work is of reasonably similar hours and working conditions to the employee's previous employment, and the one year requirement may be satisfied by cumulative periods of seasonal work;
- (3) the work must commence within 12 months of the date of the offer; and
- (4) The offer meets the conditions set forth in this section.

Authority: Sections 133, 139.48, and 5307.3, Labor Code.

Reference: Sections 139.48, and 4658, Labor Code, Del Taco v. WCAB (2000) 79 Cal.App.4th 1437, Anzelde v. WCAB (1996) 61 Cal. Comp. Cases 1458 (Writ denied), and Henry v. WCAB (1998) 68 Cal.App.4th 981.

10003. Form [DWC AD 10003 Notice of Offer of Work].

**DWC-AD 10003 NOTICE OF OFFER OF REGULAR WORK
For injuries occurring on or after 1/1/05**

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Claims Administrator: _____ Claim Number: _____
(Name of Claims Administrator)

Based on the opinion of treating physician QME AME, you are able to return to
(Name of Physician)

your usual occupation or the position you held at the time of your injury on _____.
(Date)

Date you are eligible to return to job: _____ (as stated in the above physician's report)

Employer: _____
(Name of Firm)

Job Title: _____

Starting Date: _____

This position is at the same location and shift as your pre-injury position.

This position is at a different location than your pre-injury position, as follows: _____

This position is for a different shift than your pre-injury position, as follows: _____
(start time) (end time)

You may contact _____ concerning this position. Phone No.: _____
(Name of Contact Person)

You must return the completed form to the employer or claims administrator listed here:

(Name of Employer or Claims Administrator) (Mailing address)

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

This position provides wages and compensation of \$ _____, that are equivalent to or more than the wages and compensation paid to you at the time of your injury.

I, _____, have obtained the above job offer information from your employer.
(Name of Claims Administrator)

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance. You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice.

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Claim Number _____

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on page one within 20 calendar days of receipt of the offer or it will be deemed that the employee has waived the right to object to the location or shift. The employee should keep a copy of this form for his or her records.

Name of employee: _____ Date offer received: _____

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

___ I accept this offer of regular work.

___ I reject this offer of work. Reason: _____

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

___ I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

___ I reject this offer of work. Reason: _____

___ I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

___ I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Signature

Date: _____

Proof of Service By Mail or Hand Delivery

I am a resident of the County of _____ . I am over the age of eighteen years and not a party to the within matter. My business address is:

_____.

On _____, I served the **Notice of Offer of Regular Work** on the party/parties listed below by either method of service described below:

A. Placing a true copy of the **Notice of Offer of Regular Work** in a sealed envelope with postage fully prepaid addressed to each person whose name and address is given below by depositing the envelope in the United States mail.

Or

B. Personally serving a true copy of the **Notice of Offer of Regular Work** on each person whose name and address is given below.

Enter the name of the party and indicate the type of service in the box (either A or B as described above.)

Name of Party: _____ Type of Service

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at

_____ on _____.

Signature: _____

Authority: Sections 133, 139.48, and 5307.3, Labor Code.

Reference: Sections 139.48, and 4658, Labor Code.

10004. Return to Work Program.

- (a) This section shall apply to injuries occurring on or after July 1, 2004;
- (b) An “Eligible Employer” means any employer, except the state or an employer eligible to secure the payment of compensation pursuant to subdivision (c) of Section 3700, who, based on the employer’s payroll records or other equivalent documentation or evidence, employed 50 or fewer full-time employees on the date of injury.
- (c) “Full-time employee” means an employee who, during the period of his or her employment within the year preceding the injury, worked an average of 32 or more hours per week.
- (d) The Return to Work Program is administered by the Administrative Director for the purpose of promoting the employee’s early and sustained return to work following a work-related injury or illness.
- (e) This program shall be funded by the Return to Work Fund, which shall consist of all penalties collected pursuant to Labor Code section 5814.6 and transfers made to this fund by the Administrative Director from the Workers’ Compensation Administrative Revolving Fund established pursuant to Labor Code section 62.5. The reimbursement offered to eligible employers as set forth in this section shall be available only to the extent funds are available.
- (f) An eligible employer shall be entitled to reimbursement through this program for expenses incurred to make workplace modifications to accommodate an employee’s return to modified or alternative work, up to the following maximum amounts:
 - (1) \$1,250 to accommodate each temporarily disabled employee, for expenses incurred in allowing such employee to perform modified or alternative work within physician-imposed temporary work restrictions; and
 - (2) \$2,500 to accommodate each permanently disabled employee, for expenses incurred in returning such employee to sustained modified or alternative work within physician-imposed permanent work restrictions; however, if an employer who has received reimbursement for a temporarily disabled employee under paragraph (1) is also requesting reimbursement for the same employee for accommodation of permanent disability, the maximum available reimbursement is \$2,500. For the purpose of this subdivision,

“sustained modified or alternative work” is work anticipated to last at least 12 months.

(g) Reimbursement shall be provided for any of the following expenses, provided they are specifically prescribed by a physician or are reasonably required by restrictions set forth in a medical report:

- (1) modification to worksite;
- (2) equipment;
- (3) furniture;
- (4) tools; or
- (5) any other necessary costs reasonably required to accommodate the employee’s restrictions.

(h) An eligible employer seeking reimbursement pursuant to subdivision (d) shall submit a “Request for Reimbursement of Accommodation Expenses” (Form DWC AD 10005, section 10005) to the Division of Workers’ Compensation Return to Work Program within ninety (90) calendar days from the date of the expenditure for which the employer is seeking reimbursement. As a condition to reimbursement, the expenditure shall not have been paid or covered by the employer’s insurer or any source of funding other than the employer. The filing date may be extended upon a showing of good cause for such extension. The employer shall attach to its request copies of all pertinent medical reports that contain the work restrictions being accommodated, any other documentation supporting the request, and all receipts for accommodation expenses. Requests should be sent to the mailing address for the Division of Workers’ Compensation Return to Work Program that is listed in the web site of the Division of Workers’ Compensation, at:
http://www.dir.ca.gov/dwc/dwc_home_page.htm

(i) The Administrative Director or his or her designee shall review each “Request for Reimbursement of Accommodation Expenses,” and within sixty (60) business days of receipt shall provide the employer with notice of one of the following:

- (1) that the request has been approved, together with a check for the reimbursement allowed, and an explanation of the allowance, if less than the maximum amounts set forth in subdivision (d); or
- (2) that the request has been denied, with an explanation of the basis for denial; or
- (3) that the request is deficient or incomplete and indicating what clarification or additional information is necessary.

(j) In the event there are insufficient funds in the Return to Work Fund to fully reimburse an employer or employers for workplace modification expenses as required

by this section, the Administrative Director shall utilize the following priority list in establishing the amount of reimbursement or whether reimbursement is allowed, in order of decreasing priority as follows:

- (1) Employers who have not previously received any reimbursement under this program;
- (2) Employers who have not previously received any reimbursement under this program for the employee who is the subject of the request;
- (3) Employers who are seeking reimbursement for accommodation required in returning a permanently disabled employee to sustained modified or alternative work; and,
- (4) Employers who are requesting reimbursement for accommodation required by a temporarily disabled employee.

(k) An eligible employer may appeal the Administrative Director's notice under subdivision (i) by filing a Declaration of Readiness to Proceed with the local district office of the Workers' Compensation Appeals Board within twenty calendar days of the issuance of the notice, together with a petition entitled "Appeal of Administrative Director's Reimbursement Allowance," setting forth the basis of the appeal. A copy of the Declaration of Readiness to Proceed and the petition shall be concurrently served on the Administrative Director.

Authority: Sections 133, 139.48, and 5307.3, Labor Code.

Reference: Section 62.5, 139.48, and 5814.6, Labor Code.

10005. Form [DWC AD 10005 Request for Reimbursement of Accommodation Expenses].

**Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005**

Name of Employer: _____ Address of Employer: _____

Phone Number: _____ Name of Injured Employee: _____

WCAB number (if applicable): _____ Claim Number _____

Job Title (at time of injury): _____

Job Duties (attach job description if available): _____

Date of Injury: _____

Reimbursement is requested for expenses to accommodate a:

_____ temporarily disabled employee (\$1250 maximum)

_____ permanently disabled employee (\$2500 maximum)

Employee's work restrictions and accommodation required (attach documentation regarding the need for accommodation):

Itemized list of costs for which reimbursement is requested (attach all receipts):

1. Modification to worksite (list all work done and total cost) _____ Cost _____

2. Equipment, furniture and/or tools (list each item and cost) _____ Cost _____

3. Any other accommodation expenses: _____ Cost _____

(Attach additional sheets if necessary)

Total Costs: _____

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

Signature of employer or employer's representative _____ Date _____

Authority: Sections 133, 139.48, and 5307.3, Labor Code.

Reference: Section 62.5, 139.48, and 5814.6, Labor Code.

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

Employer (name of firm) _____ is offering you the position of a
(name of job) _____.
You may contact _____ concerning this offer. Phone No.: _____
Date of offer: _____ Date job starts: _____
Claims Administrator: _____ Claim Number: _____

NOTICE TO EMPLOYEE Name of employee: _____
Date of Injury: _____ Date offer received: _____

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work or Alternative Work

- A. You cannot perform the essential functions of the job; or
- B. The job is not a regular position lasting at least 12 months; or
- C. Wages and compensation offered are less than 85% paid at the time of injury; or
- D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

___ I accept this offer of Modified or Alternative work.
___ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

Signature Date _____

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection. (A.D., "SJDB," Division of Workers' Compensation, P.O. Box 420603, S.F., CA 94142-0603)
If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

POSITION REQUIREMENTS

Actual job title:	
Wages: \$	per Hour ___ Week ___ Month ___
Is salary of modified/alternative work the same as pre-injury job?	Yes ___ No ___
Is salary of modified/alternative work at least 85% of pre-injury job?	Yes ___ No ___
Will job last at least 12 months?	Yes ___ No ___
Is the job a regular position required by the employer's business?	Yes ___ No ___
Work location:	_____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): _____ Date of report: _____
Date of last payment of Temporary Total Disability:

Preparer's Name:
Preparer's Signature: _____ Date _____

**DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04**

Proof of Service By Mail

I am a citizen of the United States and a resident of the County of _____ . I am over the age of eighteen years and not a party to the within matter.

My business address is:

On _____, I served the **Notice of Offer of Modified or Alternative Work** on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U. S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____ on _____.

Signature: _____

Copies Served On:

Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005

Name of Employer: _____ Address of Employer: _____

Phone Number: _____ Name of Injured Employee: _____

WCAB number (if applicable): _____ Claim Number _____

Job Title (at time of injury): _____

Job Duties (attach job description if available): _____

Date of Injury: _____

Reimbursement is requested for expenses to accommodate a:

_____ temporarily disabled employee (\$1250 maximum)

_____ permanently disabled employee (\$2500 maximum)

Employee's work restrictions and accommodation required (attach treating physician's, QME or AME report):

Itemized list of costs for which reimbursement is requested (attach all receipts):

1. Modification to worksite (list all work done and total cost) _____ Cost _____

2. Equipment, furniture and/or tools (list each item and cost) _____ Cost _____

3. Any other accommodation expenses: _____ Cost _____

(Attach additional sheets if necessary)

Total Costs: _____

The above costs have not been paid for and are not covered by the insurance carrier or any other source.

I declare that the information I have provided on this form is true and correct under penalty of perjury.

Signature of employer or employer's representative _____ Date _____

**Request for Reimbursement of Accommodation Expenses
For injuries on or after July 1, 2004
Form DWC AD 10005**