

**§ 9785. Reporting Duties of the Primary Treating Physician.**

(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(3) "Claims administrator" is 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 administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) "Medical determination" means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) "Continuing medical treatment" is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

(7) "Future medical treatment" is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) "Permanent and stationary status" is the point 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.

(b)(1) An employee shall have no more than one primary treating physician at a time.

(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§ 4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or

(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, or if the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4061 and 4062. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4610, 4061 and 4062.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination in accordance with subdivision (e)(1).

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is released from care;

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code Section 4636(b);

(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A

response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3."

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

(h) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

**§ 9786. Petition for Change of Primary Treating Physician.**

(a) A claims administrator desiring a change of primary treating physician pursuant to Labor Code Section 4603 shall file with the Administrative Director a petition, verified under penalty of perjury, on the "Petition for Change of Primary Treating Physician" form (DWC-Form 280 (Part A)) contained in Section 9786.1.

The petition shall be accompanied by supportive documentary evidence relevant to the specific allegations raised. A proof of service by mail declaration shall be attached to the petition indicating that (1) the completed petition (Part A), (2) the supportive documentary evidence and (3) a blank copy of the "Response to Petition for Change of Primary Treating Physician", (DWC-Form 280 (Part B)), were served on the employee or, the employee's attorney, and the employee's current primary treating physician.

(b) Good cause to grant the petition shall be clearly shown by verified statement of facts, and, where appropriate, supportive documentary evidence. Good cause includes, but is not limited to any of the following:

(1) The primary treating physician has failed to comply with Section 9785, subdivisions (e), (f)(1-7), or (g) by not timely submitting a required report or submitting a report which is inadequate due to material omissions or deficiencies;

(2) The primary treating physician has failed to comply with subdivision (f)(8) of Section 9785 by failing to submit timely or complete progress reports on two or more occasions within the 12-month period immediately preceding the filing of the petition;

(3) A clear showing that the current treatment is not consistent with the treatment plan submitted pursuant to Section 9785, subdivisions (e) or (f);

(4) A clear showing that the primary treating physician or facility is not within a reasonable geographic area as determined by Section 9780(e).

(5) A clear showing that the primary treating physician has a possible conflict of interest, including but not limited to a familial, financial or employment relationship with the employee, which has a significant potential for interfering with the physician's ability to engage in objective and impartial medical decision making.

(c)(1) Where good cause is based on inadequate reporting under subdivisions (b)(1) or (b)(2), the petition must show, by documentation and verified statement, that the claims administrator notified the primary treating physician or facility in writing of the complete requirements of Section 9785 prior to the physician's failure to properly report.

(2) Good cause shall not include a showing that current treatment is inappropriate or that there is no present need for medical treatment to cure or relieve from the effects of the injury or illness. The claims administrator's contention that current treatment is inappropriate, or that the employee is no longer in need of medical treatment to cure or relieve from the effects of the

injury or illness should be directed to the Workers' Compensation Appeals Board, not the Administrative Director, in support of a Petition for Change of Primary Treating Physician.

(3) Where an allegation of good cause is based upon failure to timely issue the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, within 5 working days of the initial examination pursuant to Section 9785(e)(1) or (e)(2), the petition setting forth such allegation shall be filed within 90 days of the initial examination.

(4) The failure to verify a letter response to a request for information made pursuant to Section 9785(f)(7), failure to verify a narrative report submitted pursuant to Section 9785(f)(8), or failure of the narrative report to conform to the format requirements of Section 9785(f)(8) shall not constitute good cause to grant the petition unless the claims administrator submits documentation showing that the physician was notified of the deficiency in the verification or reporting format and allowed a reasonable time to correct the deficiency.

(d) The employee, his or her attorney, and/or the primary treating physician may file with the Administrative Director a response to said petition, provided the response is verified under penalty of perjury and is filed and served on the claims administrator and all other parties no later than 20 days after service of the petition. The response may be accompanied by supportive documentary evidence relevant to the specific allegations raised in the petition. The response may be filed using the "Response to Petition for Change of Primary Treating Physician" form (DWC-Form 280 (Part B)) contained in Section 9786.1. Where the petition was served by mail, the time for filing a response shall be extended pursuant to the provisions of Code of Civil Procedure Section 1013. Unless good cause is shown, no other document will be considered by the Administrative Director except for the petition, the response, and supportive documentary evidence.

(e) The Administrative Director shall, within 45 days of the receipt of the petition, either:

(1) Dismiss the petition, without prejudice, for failure to meet the procedural requirements of this Section;

(2) Deny the petition pursuant to a finding that there is no good cause to require the employee to select a primary treating physician from the panel of physicians provided in the petition;

(3) Grant the petition and issue an order requiring the employee to select a physician from the panel of physicians provided in the petition, pursuant to a finding that good cause exists therefor;

(4) Refer the matter to the Workers' Compensation Appeals Board for hearing and determination by a Workers' Compensation Administrative Law Judge of such factual determinations as may be requested by the Administrative Director; or

(5) Issue a Notice of Intention to Grant the petition and an order requiring the submission of additional documents or information.

(f) The claims administrator's liability to pay for medical treatment by the primary treating physician shall continue until an order of the Administrative Director issues granting the petition.

(g) The Administrative Director may extend the time specified in Subsection (e) within which to act upon the claims administrator's petition for a period of 30 days and may order a party to submit additional documents or information.

**§ 9787. Appeal from Administrative Director's Order Granting or Denying Petition for Change of Primary Treating Physician.**

Any order denying or granting the claims administrator's petition whether issued with or without hearing, shall be final and binding upon the parties unless within 20 days from service thereof the aggrieved party petitions the Workers' Compensation Appeals Board for relief in the manner prescribed by Section 10950 of the Board's Rules of Practice and Procedure.

**§ 10950. Petitions Appealing Orders Issued by the Administrative Director.**

Except as provided in Rule 10953, petitions appealing orders issued by the Administrative Director shall be filed in accordance with the provisions of Article 9 (section 10290 et seq.) of the Rules of the Court Administrator. Where a workers' compensation judge has determined such an appeal, any aggrieved party may file a petition for reconsideration in accordance with the provisions of Labor Code section 5900 et seq. and Appeals Board Rules 10840 et seq.

**§ 9767.6. Treatment and Change of Physicians Within MPN.**

(a) When the injured covered employee notifies the employer or insured employer of the injury or files a claim for workers' compensation with the employer or insured employer, the employer or insurer shall arrange an initial medical evaluation with a MPN physician in compliance with the access standards set forth in section 9767.5.

(b) Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall provide for all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 or, prior to the adoption of these guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and for all injuries not covered by the ACOEM guidelines or guidelines adopted by the Administrative Director, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), 2nd Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com).

(c) The employer or insurer shall provide for the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars (\$10,000).

(d) The insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

(e) At any point in time after the initial medical evaluation with a MPN physician, the covered employee may select a physician of his or her choice from within the MPN. Selection by the covered employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

**(f) The employer or insurer shall not be entitled to file a Petition for Change of Treating Physician, as set forth at section 9786, if a covered employee is treating with a physician within the MPN.**

### PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

<input type="checkbox"/> Periodic Report (required 45 days after last report) <input type="checkbox"/> Change in treatment plan <input type="checkbox"/> Released from care
<input type="checkbox"/> Change in work status <input type="checkbox"/> Need for referral or consultation <input type="checkbox"/> Response to request for information
<input type="checkbox"/> Change in patient's condition <input type="checkbox"/> Need for surgery or hospitalization <input type="checkbox"/> Request for authorization
<input type="checkbox"/> Other:

**Patient:**

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Claims Administrator:**

Name \_\_\_\_\_ Claim Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

**Employer name:**

Employer Phone (\_\_\_\_) \_\_\_\_\_

The information below must be provided. You may use this form or you may substitute or append a narrative report.

**Subjective complaints:**

**Objective findings:** (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

**Diagnoses:**

1. \_\_\_\_\_ ICD-9 \_\_\_\_\_
2. \_\_\_\_\_ ICD-9 \_\_\_\_\_
3. \_\_\_\_\_ ICD-9 \_\_\_\_\_

**Treatment Plan:** (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?)

## PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

**Work Status:** This patient has been instructed to:

- Remain off-work until \_\_\_\_\_.
- Return to *modified* work on \_\_\_\_\_ with the following limitations or restrictions  
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):
- Return to full duty on \_\_\_\_\_ with no limitations or restrictions.

**Primary Treating Physician:** (original signature, do not stamp)      Date of exam: \_\_\_\_\_

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: \_\_\_\_\_ Cal. Lic. # \_\_\_\_\_  
Executed at: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

This form is required to be used for ratings prepared pursuant to the 1997 Permanent Disability Rating Schedule. It is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

**This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.**

**Patient:**

Last Name \_\_\_\_\_ Middle Initial \_\_\_\_ First Name \_\_\_\_\_ Sex \_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_ Phone No. \_\_\_\_\_

**Claims Administrator/Insurer:**

Name \_\_\_\_\_ Claim No. \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**Employer:**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Date of Injury \_\_\_\_\_ Last date \_\_\_\_\_ Date of current \_\_\_\_\_ Permanent & \_\_\_\_\_  
Date worked Date examination Date Stationary date Date

**Description of how injury/illness occurred** (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

**Patient's Complaints:**

Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

**Relevant Medical History:**

**Objective Findings:**

**Physical Examination:** (Describe all relevant findings; include any specific measurements indicating atrophy, range of motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

**Diagnostic tests results** (X-ray/Imaging/Laboratory/etc.)

**Diagnoses** (List each diagnosis; ICD-9 code must be included)

ICD-9

- |    |       |       |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

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	Yes	No	Cannot Determine
Can this patient now return to his/her usual occupation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If not, can the patient perform another line of work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

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**Subjective Findings:** Provide your professional assessment of the subjective factors of disability, based on your evaluation of the patient's complaints, your examination, and other findings. List specific symptoms (e.g. pain right wrist) and their frequency, severity, and/or precipitating activity using the following definitions:

**Severity:** Minimal pain - an annoyance, causes no handicap in performance.  
Slight pain - tolerable, causes some handicap in performance of the activity precipitating pain.  
Moderate pain - tolerable, causes marked handicap in the performance of the activity precipitating pain.  
Severe pain - precludes performance of the activity precipitating pain.

**Frequency:** Occasional - occurs roughly one fourth of the time.  
Intermittent - occurs roughly one half of the time.  
Frequent - occurs roughly three fourths of the time.  
Constant - occurs roughly 90 to 100% of time.

**Precipitating activity:** Description of precipitating activity gives a sense of how often a pain is felt and thus may be used with or without a frequency modifier. If pain is constant during precipitating activity, then no frequency modifier should be used. For example, a finding of "moderate pain on heavy lifting" connotes that moderate pain is felt whenever heavy lifting occurs. In contrast, "intermittent moderate pain on heavy lifting" implies that moderate pain is only felt half the time when engaged in heavy lifting.

	Yes	No	Cannot determine
<b><u>Pre-Injury Capacity</u></b> Are there any activities at home or at work that the patient cannot do as well now as could be done prior to this injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please describe pre-injury capacity and current capacity (e.g. used to regularly lift a 30 lb. child, now can only lift 10 lbs.; could sit for 2 hours, now can only sit for 15 mins.)

- 1.
- 2.
- 3.
- 4.

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

**Preclusions/Work Restrictions**

	Yes	No	Cannot determine
Are there any activities the patient cannot do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please describe all preclusions or restrictions related to work activities (e.g. no lifting more than 10 lbs. above shoulders; must use splint; keyboard only 45 mins. per hour; must have sit/stand workstation; no repeated bending). Include restrictions which may not be relevant to current job but may affect future efforts to find work on the open labor market (e.g. include lifting restriction even if current job requires no lifting; include limits on repetitive hand movements even if current job requires none).

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**Medical Treatment:** Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) Also, describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc.

**Comments:**

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

**Apportionment:**

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

**Labor Code Section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee**

- (a) Apportionment of permanent disability shall be based on causation.
- (b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
- (c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.
- (d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

**Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards**

- (a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.
- (b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.
- (c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

(A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

	Yes	No
Is the permanent disability directly caused, by an injury or illness arising out of and in the course of employment?	<input type="checkbox"/>	<input type="checkbox"/>
Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records:

Written Job Description:

Other:

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)**

**Primary Treating Physician (original signature, do not stamp)**

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code §139.3.

Signature: \_\_\_\_\_ Cal. Lic. # : \_\_\_\_\_

Executed at: \_\_\_\_\_ Date: \_\_\_\_\_  
(County and State)

Name (Printed): \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

This form is required to be used for ratings prepared pursuant to the 2005 Permanent Disability Rating Schedule and the AMA Guides to the Evaluation of Permanent Impairment (5<sup>th</sup> Ed.). It is designed to be used by the primary treating physician to report the initial evaluation of permanent impairment to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

**This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.**

**Patient:**

Last Name \_\_\_\_\_ Middle Initial \_\_\_\_ First Name \_\_\_\_\_ Sex \_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Social Security Number \_\_\_\_\_ Phone No. \_\_\_\_\_

**Claims Administrator/Insurer:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**Employer:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**Treating Physician:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Date of Injury \_\_\_\_\_ Last date \_\_\_\_\_ Permanent & \_\_\_\_\_ Date of current \_\_\_\_\_  
*Date worked Date Stationary Date examination Date*

**Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):**

**Patient's Complaints:**

STATE OF CALIFORNIA  
 Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

**Relevant Medical History:**

**Objective Findings:**

**Physical Examination:** Describe all relevant findings as required by the AMA Guides, 5<sup>th</sup> Edition. Include any specific measurements indicating atrophy, range of motion, strength, etc. Include bilateral measurements - injured/uninjured - for injuries of the extremities.

**Diagnostic tests results** (X-ray/Imaging/Laboratory/etc.)

<b>Diagnoses</b> (List each diagnosis; ICD-9 code must be included)	<b>ICD-9</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**Impairment Rating:**

Report the whole person impairment (WPI) rating for each impairment using the AMA Guides, 5<sup>th</sup> Edition, and explain how the rating was derived. List tables used and page numbers.

Impairment	WPI%	Table #(s).	Page #(s)
Explanation			
Impairment	WPI%	Table #(s).	Page #(s)
Explanation			
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STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

**Pain assessment:**

If the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating under Chapters 3-17 of the AMA Guides, 5<sup>th</sup> Edition, specify the additional whole person impairment rating (0% up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

**Apportionment:**

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

**Labor Code section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee**

(a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

**Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards**

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

A) Hearing.

(B) Vision.

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

	Yes	No
Is the permanent disability directly caused, by an injury or illness arising out of and in the course of employment?	<input type="checkbox"/>	<input type="checkbox"/>

Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>
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If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

Division of Workers' Compensation

**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

**Future Medical Treatment:** Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) And describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc.

**Comments:**

**Functional Capacity Assessment:**

**Note: The following assessment of functional capacity is to be prepared by the treating physician, solely for the purpose of determining a claimant's ability to return to his or her usual and customary occupation, and will not be considered in the permanent impairment rating.**

Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY:

10 lbs.  20 lbs.  30 lbs.  40 lbs.  50 or more lbs.

FREQUENTLY LIFT and/or CARRY:

10 lbs.  20 lbs.  30 lbs.  40 lbs.  50 or more lbs.

OCCASIONALLY LIFT and/or CARRY:

10 lbs.  20 lbs.  30 lbs.  40 lbs.  50 or more lbs.

STAND and/or WALK a total of:

Less than 2 HOURS per 8 hour day  
 Less than 4 HOURS per 8 hour day  
 Less than 6 HOURS per 8 hour day  
 Less than 8 HOURS per 8 hour day

**SIT a total of:**

Less than 2 HOURS per 8 hour day  
 Less than 4 HOURS per 8 hour day  
 Less than 6 HOURS per 8 hour day  
 Less than 8 HOURS per 8 hour day

PUSH and/or PULL (including hand or foot controls):

UNLIMITED

LIMITED (Describe degree of limitation)

STATE OF CALIFORNIA  
 Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

ACTIVITIES ALLOWED:

	Frequently	Occasionally	Never
Climbing	[ ]	[ ]	[ ]
Balancing	[ ]	[ ]	[ ]
Stooping	[ ]	[ ]	[ ]
Kneeling	[ ]	[ ]	[ ]
Crouching	[ ]	[ ]	[ ]
Crawling	[ ]	[ ]	[ ]
Twisting	[ ]	[ ]	[ ]
Reaching	[ ]	[ ]	[ ]
Handling	[ ]	[ ]	[ ]
Fingering	[ ]	[ ]	[ ]
Feeling	[ ]	[ ]	[ ]
Seeing	[ ]	[ ]	[ ]
Hearing	[ ]	[ ]	[ ]
Speaking	[ ]	[ ]	[ ]

Describe in what ways the impaired activities are limited:

Environmental restrictions (e.g. heights, machinery, temperature extremes, dust, fumes, humidity, vibration etc.)

Can this patient now return to his/her usual occupation? Yes No

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records:

Written Job Description:

STATE OF CALIFORNIA  
Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)**

Other:

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**Primary Treating Physician (original signature, do not stamp)**

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code §139.3.

Signature: \_\_\_\_\_

Cal. Lic. # : \_\_\_\_\_

Executed at: \_\_\_\_\_

Date: \_\_\_\_\_

(County and State)

Name (Printed): \_\_\_\_\_

Specialty: \_\_\_\_\_

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION  
**ADMINISTRATIVE DIRECTOR**  
Post Office Box 420603  
San Francisco, CA 94142

**PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN**  
(LABOR CODE § 4603 & TITLE 8, CALIFORNIA CODE OF REGULATIONS, § 9786)

***(Print or Type Names and Addresses)***

WCAB Case Nos. (If any): \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

EMPLOYEE'S ADDRESS: \_\_\_\_\_

EMPLOYEE'S ATTORNEY: \_\_\_\_\_

EMPLOYEE'S ATTORNEY'S ADDRESS \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

CLAIMS ADMINISTRATOR: \_\_\_\_\_

CLAIMS ADMINISTRATOR'S ADDRESS: \_\_\_\_\_

CLAIMS ADMINISTRATOR'S CLAIM NUMBER(S): \_\_\_\_\_

NAME OF PRIMARY TREATING PHYSICIAN \_\_\_\_\_

PRIMARY TREATING PHYSICIAN'S ADDRESS: \_\_\_\_\_

PHYSICIAN PANEL: List below the **NAMES, ADDRESSES and MEDICAL SPECIALTIES** (e.g.-orthopedics, cardiology, etc.) of a panel of FIVE (5) physicians (to include one chiropractor if the employee is being treated by a chiropractor) available to provide treatment of the employee's injury in the event this petition is granted.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Petitioner states that the following constitutes good cause for issuance of an *Order Granting Petition For Change Of Primary Treating Physician*: (Additional sheets may be attached if necessary)

**NOTE:** Attach to this Petition any supportive evidence (medical reports, declarations, etc.) that establishes good cause for the Petition to be granted. (See Title 8, California Code of Regulations, Section 9786)

### VERIFICATION

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

EXECUTED AT \_\_\_\_\_, CALIFORNIA ON \_\_\_\_\_  
(City) (Date)

BY: \_\_\_\_\_ // \_\_\_\_\_  
Original Signature of Petitioner's Representative // Name of Petitioner's Representative Preparing the Petition  
Preparing the Petition (Print or type)

\_\_\_\_\_  
(Address of Petitioner)

**YOU MUST ATTACH A PROOF OF SERVICE BY MAIL DECLARATION INDICATING THAT: (1) PART A (PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN) AND PART B (RESPONSE TO PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN) OF THIS FORM AND (2) ALL SUPPORTIVE EVIDENCE WERE MAILED TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY, AND THE PRIMARY TREATING PHYSICIAN.**

***Notice to Employee/Employee's Attorney and Primary Treating Physician:***

**Pursuant to Title 8, California Code of Regulations, Section 9786(d), you may file with the Administrative Director a RESPONSE to this petition within 20 days from the date the petition was served on you. Your Response must be submitted using the *Response to Petition for Change of Treating Physician* form which is contained in Part B on Pages 3 and 4 of this form. You may attach additional sheets as needed to the Response form.**

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION  
ADMINISTRATIVE DIRECTOR  
Post Office Box 420603  
San Francisco, CA 94142

**RESPONSE TO PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN**  
(LABOR CODE § 4603 & TITLE 8, CALIFORNIA CODE OF REGULATIONS, § 9786(d))

***(Print or type names and addresses)***

WCAB Case Nos. (If any): \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

EMPLOYEE'S ATTORNEY \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

CLAIMS ADMINISTRATOR: \_\_\_\_\_

CLAIMS ADMINISTRATOR'S CLAIM NUMBER: \_\_\_\_\_

NAME OF PRIMARY TREATING PHYSICIAN \_\_\_\_\_

The petition filed by or on behalf of the Claims Administrator does not establish good cause for the issuance of an *Order Granting Petition For Change Of Primary Treating Physician based on the following*: (additional sheets may be attached if necessary)

**IMPORTANT:** Attach to this Response any supportive documentary evidence (medical reports, affidavit and declaration, etc.) which establishes that there is not good cause for the Administrative Director to grant the Petition for Change of Primary Treating Physician. (See *Title 8, California Code of Regulations, § 9786*)

## VERIFICATION

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

EXECUTED AT \_\_\_\_\_, CALIFORNIA ON \_\_\_\_\_  
(City) (Date)

BY: \_\_\_\_\_ // \_\_\_\_\_  
Original Signature of Person Preparing the Response // Name of Person Preparing the Response (Print or type)

Address:  
-----

***NOTICE TO EMPLOYEE/EMPLOYEE'S ATTORNEY: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE CLAIMS ADMINISTRATOR OR ITS ATTORNEY, AND THE PRIMARY TREATING PHYSICIAN.***

***NOTICE TO PRIMARY TREATING PHYSICIAN: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE CLAIMS ADMINISTRATOR OR ITS ATTORNEY, AND THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY.***

### **PROOF OF SERVICE BY MAIL**

On \_\_\_\_\_ I served a copy of this Response to Petition for Change of Treating Physician on  
(date)  
\_\_\_\_\_ at \_\_\_\_\_ and  
(Claims Administrator or its Attorney) (address)  
\_\_\_\_\_ at \_\_\_\_\_ by  
(Primary Treating Physician or Employee/  
Employee's Attorney) (address)

placing a true copy enclosed in a sealed envelope, addressed as indicated above and with postage fully prepaid, in the U.S. Mail at \_\_\_\_\_, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

\_\_\_\_\_  
Original Signature of Declarant // Name of Declarant (Print or Type)