

Sedgwick Claims Management Services, Inc.  
Po Box 14152  
Lexington, KY 40512-4152



Sedgwick.com  
Phone: (800)705-9423  
Fax: (859)264-4061

June 20, 2018

Deborah L. Clarke  
30751 El Corazon Apt 116  
Rancho Santa Margarita, CA 92688

RE: Employee: Deborah L. Clarke  
Employer: CVS Pharmacy, Inc.  
Claim Number: 30189866969-0001  
Date of Injury: 04/04/2018

**NOTICE OF DENIAL OF CLAIM FOR  
WORKERS' COMPENSATION BENEFITS**

Sedgwick is handling your workers' compensation claim on behalf of CVS Pharmacy, Inc.. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

- After careful consideration of all available information, we are denying liability for your claim of injury. Workers' Compensation benefits are being denied because there is no substantial medical evidence that supports a claim for a cumulative trauma injury 5/5/2017 - 4/4/2018.  
 A copy of the report is attached to this notice.
- After careful consideration of all available information, we are accepting liability only for your claim of injury to . Liability is being denied for because .  
 A copy of the report is attached to this notice.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claim administrator, Labor Code section 5402 (c) provides that within one working day after you file the claim form, the employer shall authorized the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such medical treatment until the claims administrative accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars (\$10,000).

Unless you have done so already, you should immediately send me all medical treatment bills for consideration of payment for medical services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected.



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If you disagree with the decision to deny your claim and wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

We \_\_\_\_\_ the comprehensive medical evaluation of \_\_\_\_\_ and \_\_\_\_\_. If you choose to dispute this decision you may file an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB).

Since you have already received a comprehensive medical evaluation, if you disagree with the decision to deny your claim, please contact me Lizpeth Broguiere (714)572-4837 to arrange to return to the same medical evaluator for a new evaluation.

If you are represented, you may contact your attorney with any questions.

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

**Guidebook for Injured Workers:**

<http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html>

**Chapter 2: After You Get Hurt on the Job**

<http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf>

**Chapter 4: Resolving Problems with Medical Care and Medical Reports:**

<http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf>

**Chapter 9: For More Information and Help**

<http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf>

**The State of California requires that you be given the following information:**

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call me Lizpeth Broguiere (714)572-4837. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not me Lizpeth Broguiere (714)572-4837.

For information about the workers' compensation claims process and your rights and obligations, go to [www.dir.ca.gov](http://www.dir.ca.gov) or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

**Keep this notice. It contains important information about your workers' compensation benefits.**

Sedgwick cannot agree at this time to provide notices electronically via email.



Sedgwick manages claims for CVS Pharmacy, Inc. on behalf of XL Insurance America, Inc..

Sincerely,

Lizpeth Broguiere  
Claims Examiner

Enclosures

- Medical Reports(s) (if applicable)
- QME Panel request form (QME Form 105 and attachment) (to unrepresented employees)

cc: File  
Julie Feng  
Natalia Foley



6/22/2018

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State of California, Division of Workers' Compensation  
REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL  
(Unrepresented Employee)

TO REQUEST A QUALIFIED MEDICAL EVALUTOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:

1. Complete this form (print or type the information). Sign and date at bottom.
2. If the request is made to determine if the injury is work-related, include a copy of the claims administrator's notice that the claim was denied, or a copy of the claims administrator's request for an evaluation.
3. Complete the attached Proof of Service.
4. For Employee: Mail the completed signed form and Proof of Service to: Division of Workers' Compensation – Medical Unit  
P.O. Box 71010, Oakland, CA 94612  
(510) 286-3700 or (800) 794-6900
5. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.
6. For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.

**Panel Request Information:**

Date of Injury: 04/04/2018 Claim Number: 30189866969-0001 Specialty Requested:

(Select only ONE specialty)

Requesting Party:  Employee  Claims Administrator  Defense Attorney

**Reason for QME Panel Request (check one):**

- To determine if the injury is work-related (attach claims administrator's notice that claim was denied or a copy of the claims administrator's request for an evaluation).
- Objection to Primary Treating Physician's determination regarding temporary disability, permanent disability, or the need for future medical care.
- Work injury claim is accepted for one or more body parts, there is a dispute over additional body parts.
- Other (specify non-medical treatment dispute):

**Employee Information**

First Name: Deborah Middle Initial: L Last Name: Clarke

Street Address or P.O. Box: 30751 El Corazon Apt 116

City: Rancho Santa Margarita State: CA Zip Code: 92688

If currently not living in state, enter the California zip code on date of injury:

If never resided in state, enter California zip code agreed on for the evaluation:

**Employer/Claims Administrator Information**

Employer: GARFIELD BEACH CVS, L.L.C. Zip Code of Employer: 92679

Claims Administrator Company Name: Sedgwick Claims Management Services, Inc Adjuster/Contact Name (if known): Lizpeth Broguiere

Street Address or P.O. Box: Po Box 14152

City: Lexington State: Ky Zip Code: 40512-4152 Phone No.: (714) 572-4837

Requestor Signature: \_ Date:

QME Form 105 (rev. 09/15)

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## PROOF OF SERVICE

**Instructions:**

1. Complete the Proof of Service.
2. For Employee: Mail the completed signed form and Proof of Service to: Division of Workers' Compensation – Medical Unit  
P.O. Box 71010, Oakland, CA 94612  
(510) 286-3700 or (800) 794-6900
3. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.
4. For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.

I declare that I am a resident of or employed in the county of \_\_\_\_\_, California; I am over the age of eighteen years.

On \_\_\_\_\_ I served the attached completed Form 105 on the following parties:

by mail to:

Name of Employee or Claims Administrator

Street Address

City, State, Zip code

by hand-delivery to:

Name

Street Address

City, State, Zip code

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

Executed on \_\_\_\_\_, at \_\_\_\_\_, California

Type or Print Name:

Signature:



**For Use with the QME Panel Request Form 105**

**MD/DO SPECIALTY CODES**

MAA Anesthesiology	MOP Ophthalmology
MAI Allergy & Immunology	MOS Orthopedic Surgery (other than Spine or Hand)
MPA Pain Medicine	MNB Orthopedic Surgery - Spine
MDE Dermatology	MHH Orthopedic Surgery - Hand
MAI Dermatology-Allergy & Immunology	MTO Otolaryngology
MEM Emergency Medicine	MHA Pathology
MTT Emergency Medicine-Toxicology	MPR Physical Medicine & Rehabilitation
MFP Family Practice	MPA Physical Medicine & Rehabilitation – Pain Medicine
MPM General Preventive Medicine	MPS Plastic Surgery (other than Hand)
MTT General Preventive Medicine – Toxicology	MHH Plastic Surgery – Hand
MMM Internal Medicine	MPD Psychiatry (other than Pain Medicine)
MAI Internal Medicine-Allergy & Immunology	MPA Psychiatry – Pain Medicine
MMV Internal Medicine – Cardiovascular Disease	MSY Surgery (other than Spine or Hand)
MME Internal Medicine - Endocrinology Diabetes & Metabolism	MHH Surgery - Hand
MMG Internal Medicine – Gastroenterology	MSG Surgery- General Vascular
MMH Internal Medicine – Hematology	MTS Thoracic Surgery
MMI Internal Medicine – Infectious Disease	MJU Urology
MMO Internal Medicine – Medical Oncology	
MMN Internal Medicine – Nephrology	<i>NON-MD/DO SPECIALTIES CODES</i>
MMP Internal Medicine – Pulmonary Disease	ACA Acupuncture
MMR Internal Medicine – Rheumatology	DCH Chiropractic
MPN Neurology	DEN Dentistry
MPA Neurology – Pain Medicine	OPT Optometry
MNS Neurological Surgery (other than Spine)	POD Podiatry
MNB Neurological Surgery – Spine	PSY Psychology
MOG Obstetrics & Gynecology	
MOQ Medicine Otherwise Qualified	
MPO Occupational Medicine	
MTT Occupational Medicine – Toxicology	

***Do not file this page with your form!***



# HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR IF YOU DO NOT HAVE AN ATTORNEY

(Attachment to Form 105)

The purpose of a Qualified Medical Evaluator (QME) examination is to obtain a second medical opinion to help resolve disputed medical issues in your workers' compensation claim(s). If you are an injured worker who is not represented by an attorney, use QME Form 105 to obtain a panel of three QMEs, one of which will examine you in the event there is a disagreement over some of the opinions of your treating physician or there is a need to determine if the claimed injury is work related. The QME report must discuss all of the disputed and unresolved issues in your claim that need a medical opinion. An injured worker has the first opportunity to choose the type of physician to perform the exam. If you are an injured worker requesting a QME panel, write the medical specialty you prefer for the QME where indicated, complete the rest of the form, date and sign it, and return it to the DWC Medical Unit. You are required to send a copy of your completed Form 105 to the employer/insurer as well. **If you do not request a panel within ten (10) days of being asked to do so by the employer/insurer, then the employer/insurer has the right to request the panel and choose the medical specialty.** The employer/insurer may not submit Form 105 until ten (10) days have passed after the form was given to the injured worker with the instruction to send the completed form to the DWC Medical Unit.

After you receive the panel list of three QME names, you must select a doctor from the list and make an appointment with the chosen physician. If you do not select a QME from the panel, schedule an appointment with the QME and inform the employer/insurer of the choice **within 10 days of the date the Medical Unit issued the panel**, you may lose the right to choose the QME and the exam date. After the examination is scheduled, you must tell the employer/insurer the time and date of your appointment.

In an unrepresented case, the Medical Unit must issue a panel within twenty working days of its receipt of a request to issue a QME panel, or you may select any QME of your choice to do the evaluation within a reasonable geographic distance from your home. Instructions for completing the form are discussed in the table below.

Field	Instruction	Required or Not
Date of Injury	Insert the date the injury occurred. If this is cumulative trauma injury, insert the last date of exposure of or the last date of work. Use MM/DD/YYYY for the date.	Required
Claim number	This is the number assigned to the claim by the claims administrator.	Required
Specialty requested	Insert the specialty of the QME requested to perform the examination. Use the three letter code from the list attached to form 105.	Required
Requesting party	Check the appropriate box to indicate who is requesting the evaluation.	Required
Reason the QME panel is being requested	Indicate why the examination is being requested. The boxes in this section indicate the part of the Labor Code that describes the types of examinations. An exam to determine whether the injury is work related is a compensability examination under section 4060. An examination to determine the extent of permanent disability is a permanent disability dispute under 4061. Any other type of dispute is under section 4062.	Required
Employee information section	This section asks for the name and address of the injured worker. This is important because panels are created in part based on the location of the injured worker. If the injured worker no longer lives in California or never lived in California there is a section to state the zip code for the panel.	Required
Employer and claims administrator information	This section asks for the name of the employer and the name and address of the claims administrator (insurance company or third-party administrator, for example) and the name of the person handling	Required





Field	Instruction	Required or Not
Signature and date	The requester must sign the form where indicated. Insert the date the form is completed. Use the MM/DD/YYYY format.	Required
Proof of Service	Attached to the form is a proof of service which must be served along with the form. The purpose of the declaration of service is to show the people served with the form. Fill out the proof of service, sign where indicated, and mail to the parties along with the form.	Required

If there is a need to determine if the injury is caused by work, then you must attach the notice sent to the other side requesting an examination to determine whether the injury is the responsibility of workers' compensation or attach a copy of the claim's administrator's notice that the claim was denied. If you are the claims administrator requesting a QME panel to resolve a dispute under Labor Code section 4061 or 4062, you must attach a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical dispute determination that requires a comprehensive medical/legal report to resolve. Examples of what should be attached to the form include an objection of the claims examiner to a determination of the treating physician and requesting the injured worker to request a QME panel.

After you receive the medical evaluation from the QME, you will have the opportunity to ask the evaluator to correct factual errors or omissions in the report under section 37 of the QME rules. Under section 37, you or the claims administrator, or their representative, may use this procedure to have the examiner review facts contained in medical records that were in the examiner's possession at the time of the evaluations that are "capable of verification from written records submitted to a panel QME." To request a factual correction, you can obtain the form at [www.dir.ca.gov/dwc/forms](http://www.dir.ca.gov/dwc/forms) or contact your local Information and Assistance Office.

Finally, remember that whatever forms or documents are sent to the Medical Unit must also be sent to the other side. If you have any questions about completing this form, please contact the Information and Assistance Officer at your local Division of Workers' Compensation office.

**Do not file these instructions with your form!**



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