Broadspire®
A CRAWFORD COMPANY

PO Box 14352
Lexington, KY 40512-4352

Phone: (714) 989-4415
Fax: (859) 550-2170

May 14, 2019

DEBRA S SANCHEZ
6025 Clara St.
Bell Gardens, CA 90201

RE:	Employer:	USC
	Employee:	DEBRA S SANCHEZ
	Principal:	USC
	Date of Injury:	2/1/2019
	Claim Number:	188939486-001

NOTICE REGARDING DENIAL OF WORKERS COMPENSATION BENEFIT

Dear DEBRA S SANCHEZ:

Broadspire is handling your workers' compensation claim on behalf of USC and our principal, USC. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

Please be advised that only the sections with boxes that are ☒ are applicable.

☒ After careful consideration of all available information, we are denying liability for your claim of injury. Workers' compensation benefits are being denied because based on LC 3600(a)(10), your claim was filed after you were terminated for cause. You were terminated for cause therefore your claim is also denied based on LC 3208(b). ☐ Your denial is based on a medical report which 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 . ☐ Your denial is based on a medical report which 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 (DWC1) to your employer or Broadspire, Labor Code 5402(c) provides that within one working day after you file the claim form, the employer shall authorize 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 administrator accepts or denies liability for the claim. Until 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 send me all medical treatment bills for consideration of payment for services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected.

Please be advised that only the sections with boxes that are ☒ are applicable.

☐ You have not previously received a comprehensive medical evaluation. 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 ☐ accept / ☐ disagree with the comprehensive medical evaluation of dated . 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, Djunia J Jordan, at (714) 989-4415 to arrange to return to the same medical evaluator for a new evaluation.

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 on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Temporary Disability is discussed in chapter 5 of the Guidebook.
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

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

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 at (714) 989-4415. 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, Djunia J Jordan.

For information about the workers' compensation claims process and your rights and obligations, go to 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.

Sincerely,
Broadspire Services, Inc. on behalf of:
USC

Djunia J Jordan
Sr Claim Examiner-WC (CA)
(714) 989-4415

cc:

USCHR

File

encl: ☒ QME Form 105 (Rev. 9/15)
☒ QME Form 105 Attachment
☐ Medical Report
☐ Workers' Compensation Claim Form (DWC-1)

State of California, Division of Workers' Compensation

REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL
(Unrepresented Employee)

TO REQUEST A QUALIFED 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: 2/1/2019 **Claim Number:** 188939486-001 **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: _____ Middle Initial: _____ Last Name: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

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

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

Employer/Claims Administrator Information

Employer: USC Zip Code of Employer: 90089

Claims Administrator Company Name: Broadspire Services Adjuster/Contact Name (if known): Djunia J Jordan

Street Address or P.O. Box: PO Box 14352

City: Lexington State: KY Zip Code: 40512-4352 Phone No.: (714) 989-4415

Requestor signature: _____ **Date:** _____

attachment

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: _____

MD/DO SPECIALTY CODES

MAA Anesthesiology
MAI Allergy and Immunology
MPA Pain Medicine
MDE Dermatology
MAI Dermatology – Allergy and Immunology
MEM Emergency Medicine
MTT Emergency Medicine – Toxicology
MFP Family Practice
MPM General Preventive Medicine
MTT General Preventive Medicine – Toxicology
MMM Internal Medicine
MAI Internal Medicine – Allergy and Immunology
MMV Internal Medicine – Cardiovascular Disease
MME Internal Medicine – Endocrinology Diabetes and Metabolism
MMG Internal Medicine –- Gastroenterology
MMH Internal Medicine – Hematology
MMI Internal Medicine – Infectious Disease
MMO Internal Medicine – Medical Oncology
MMN Internal Medicine – Nephrology
MMP Internal Medicine – Pulmonary Disease
MMR Internal Medicine – Rheumatology
MPN Neurology
MPA Neurology – Pain Medicine
MNS Neurological Surgery (other than Spine)
MNB Neurological Surgery – Spine
MOG Obstetrics and Gynecology
MOQ Medicine Otherwise Qualified
MPO Occupational Medicine
MTT Occupational Medicine – Toxicology
MOP Ophthalmology
MOS Orthopedic Surgery (other than Spine or Hand)
MNB Orthopedic Surgery – Spine
MHH Orthopedic Surgery – Hand
MTO Otolaryngology
MHA Pathology
MPR Physical Medicine & Rehabilitation
MPA Physical Medicine & Rehabilitation – Pain Medicine
MPS Plastic Surgery (other than Hand)
MHH Plastic Surgery – Hand
MPD Psychiatry (other than Pain Medicine)
MPA Psychiatry – Pain Medicine
MSY Surgery (other than Spine or Hand)
MHH Surgery – Hand
MSG Surgery – General Vascular
MTS Thoracic Surgery
MUU Urology

NON-MD/DO SPECIALTY CODES

ACA Acupuncture
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology

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 fifteen 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 requestor 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 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!