Claims Management Services, Inc.
ox 51350
tario, CA 91761
Phone: (855) 238-4936 ◆ Fax: (909) 942-8918
www.sedgwick.com

sedgwick

October 7, 2019

MARVETTA JOHNSON
1022 WEST 138TH STREET
Compton, CA 90222

Chiro

RE:

Employee:	MARVETTA JOHNSON
Employee No.:	254656
Dept. No./Name:	County of Los Angeles/Probation
Claim No:	20-00878D
DOI:	08/19/19

NOTICE OF DELAY OF CLAIM FOR WORKERS' COMPENSATION BENEFITS

I am handling your workers' compensation claim on behalf of the County of Los Angeles. This notice is to advise you of the status of workers' compensation benefits for your claimed injury referenced above.

Workers' compensation benefits are being delayed because we need medical and factual evidence to substantiate industrial causation, witness statements and our complete employer level investigation. We will notify you of our decision on or before **12/22/19**

This delay of claim is related to a medical issue. To resolve this issue and allow me to make a determination on your entitlement to benefits, a comprehensive medical evaluation maybe needed. Enclosed is a form that you must submit to the state Department 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.

Although workers' compensation benefits have been delayed, you may still be eligible to continue receiving short term or long term disability benefits through the County. For more information on these disability benefits, please call the Sedgwick Disability Claims Office at 1-800-786-8600.

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 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 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 for consideration of payment, all bills for medical services provided from the date the completed claim form was given to the employer.

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

[redacted]nal information may be found in the publication: **Workers' Compensation in California: A Guidebook for [redacted]ured 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. 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, CHRISTINE ROWNEY, at (909)942-8936. 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.

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,
Sedgwick Claims Management Services, Inc.

CHRISTINE ROWNEY
(909)942-8936

Enc: QME Panel Form (QME Form 105 and attachment)

Cc: File
County of Los Angeles/Probation

PROOF OF SERVICE BY MAIL

1013a(3) CCP Revised 5/01/88

(RE: MARVETTA JOHNSON, County of Los Angeles)

STATE OF CALIFORNIA, COUNTY OF SAN BERNARDINO

I, the undersigned, hereby declare that I am over the age of eighteen years and not a party to the within action. I am employed in the County of San Bernardino and my business address is P.O. Box 51350, Ontario, CA 91761.

On 5/3/19, I served the foregoing document(s)described as:

DWC-Delay Benefit Notice, QME Panel Form (QME Form 105 and attachment)

on all interested parties in this action by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at Ontario, California, addressed as follows:

MARVETTA JOHNSON
1022 WEST 138TH STREET
Compton, CA 90222

David H. Black
3201 Pico Blvd.
Santa Monica CA. 90405

County Counsel
350 S Figueroa St. Ste 1001
LOS Angeles CA. 90071

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

CHRISTINE ROWNEY
DECLARANT NAME

DECLARANT SIGNATURE

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: 03/14/2019 Claim No: 419-02165-D Specialty Request: _____ (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 of 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 of 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: COUNTY OF LOS ANGELES Zip Code of Employer: _____

Claims Administrator Company Name: SEDGWICK Adjuster/Contact Name (if known): _____

Street Address or P.O. Box: P.O. BOX 51350

City: Ontario State: CA Zip Code: 91761 Phone No.: _____

Requestor Signature: _____ Date: _____

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 San Bernardino, California; I am over the age of eighteen years.

On 10/8/2019, I served the attached completed Form 105 on the following parties:

☑ By mail to:

SEDGWICK
Name of Employee or Claims Administrator

PO BOX 51350
Street Address

ONTARIO, CA 91761
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 10/8/19, at Ontario, California

Type or Print Name: Brandi DePhillips

Signature: Brandi DePhillips

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

MAA	Anesthesiology
MAI	Allergy and Immunology
MPA	Pain Medicine
MDE	Dermatology
MAI	Dermatology – Allergy & Immunology
MEM	Emergency Medicine
MTT	Emergency Medicine - Toxicology
MFP	Family Practice
MPM	General Preventative Medicine
MTT	General Preventative 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	Oncology – Internal Medicine
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	Opthalmology
MOS	Orthopaedic Surgery *(other than Spine or Hand)*
MNB	Orthopaedic Surgery - Spine
MHH	Orthopaedic 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!