Risk Management

Worker's Compensation

FAQ

Cancer Diagnosis

FIRESCOPE ICS 920

July 2024

Occupational Cancer FAQ sheet for Firefighters

This document serves as a general overview for firefighters regarding occupationally acquired cancer and processes related to Risk Management and Payroll. This document is not intended to replace any communications, departmental policies, procedures, or directives with your chain of command, Risk Management, Payroll, or guidance received from the Health and Safety Office, Union representative, or Relief/Benevolent Association.

Worker's Compensation laws and regulations change regularly; this document is a snapshot in time based upon Worker's Compensation laws and regulations as of January 1st, 2024. The document will be updated annually; however, it is incumbent upon the reader to understand that information in this document may have changed since its creation/latest revision.

I was just diagnosed with cancer; "As a firefighter, is this diagnosis considered work-related, and what steps should I take?"

State of California Labor Code 3212.1 provides that cancer is presumed to result from exposure to firefighting and is covered by workers' compensation, under which circumstances the presumption may be challenged by evidence if the primary site of the cancer has been established and the carcinogen is not reasonably linked to the disabling cancer. Absent this evidence, the workers' compensation appeals board is bound to find in accordance with the industrial presumption. Each cancer case is unique and needs to be evaluated/investigated and supported on its own merits by a department, risk management and/or worker's compensation representative.

Once you receive a diagnosis, do the following as soon as possible:

- Contact your department cancer support liaison or Workers' Compensation (WC) representative. Ideally, this is a sworn fire department member.
- A cancer diagnosis summary is needed to avoid delaying any claims.
    - Medical evidence via a cancer diagnosis summary from a treating physician indicating a causal link that the cancer is presumed to have developed or manifested itself and arose out of and in the course of employment as a firefighter. Absent this causal link, there may be a delay in making a liability determination.
- Notify your supervisor and/or cancer support liaison to submit WC/Injury paperwork.
- Call and/or visit Risk Management, Workers' Compensation Division, and speak with the Program Coordinator or Senior Claims Adjuster to initiate your claim and answer your questions.
    - Risk Management Contact Information
    - Risk Management Supervisor Contact Information

    - Medical Liaison Representative
- Complete ALL paperwork given to you by Risk Management or proxy to avoid delays in evaluating your case.
- Consider calling the Firefighter Cancer Support Network (FCSN).
    - Resources, tools, and mentorship assistance:
    - Contact phone number: 866-994-FCSN (3276)
    - FCSN Website: https://firefightercancersupport.org/
- Consider calling your firefighter's Relief/Benevolent Association and inquire about a Cancer Mentor.
    - Cancer Mentors are firefighters who have previously traveled the same journey you are about to begin.
    - Relief/Benevolent Association contact/address information
- Organization is essential:
    - Log all your: contacts, appointments, mileage, agency-specific documents, questions, and any other important information.
    - Promptly fill out and return all documents as directed to ensure you receive the benefits you are entitled to.
    - The above information may assist you with supplemental insurance claims.

What is a Nurse Case Manager?

A Nurse Case Manager is a nurse assigned to help you navigate your treatment and assist with any needs that arise, for example: prescriptions, home health equipment, transportation to and from appointments, hospitalization discharges and more. You are not required to have the nurse with you when you meet with your doctors. It is voluntary. If you have an attorney representing you, your attorney must approve any Nurse Case Managers before one can be assigned to work directly with you. It is recommended that your organization offer a Nurse Case Manager for all cancer claims.

Should I hire an attorney?

Hiring an attorney is at the discretion of the individual. You have the right to retain an attorney, which may prove beneficial based on your case's complexities. Attorneys cannot charge you for a consultation about your rights as a firefighter who has been diagnosed with cancer. However, it is important to note that an attorney is optional for you to receive benefits and/or medical care. When you retain an attorney, your specific agency administrator (e.g., Risk Management and/or Third-Party Administrator) can only discuss your case with them rather than directly with you.

How long does Risk Management have to accept my claim?

Labor Code 3212 and 3213.2 states it must be accepted or rejected within 75 days from the date the City or County became aware of your claim. For a cancer diagnosis, Risk Management attempts to get the appropriate medical documentation as soon as possible.

- You are entitled to receive medical care of up to $10,000 while Risk Management obtains the necessary medical information to determine your claim (also known as a delayed status).
- If you are off work during the delayed period, the wage replacement benefit (4850-time) is not paid. However, if your claim is accepted at any point, wage replacement benefits will be paid retroactively to the first date of your disability, provided the disability dates were certified by your doctor. If you have utilized paid time off, compensated time off, vacation or annual leave, the 4850 benefits will restore any time used where you were deemed medically disabled from working.
- Any medical treatment benefits received during the delayed period are paid for by the employer, City, County, or third-party administrator. If a claim is not deemed work-related, the employee is not responsible for reimbursing any costs paid during the delayed period.

Who treats me when I am diagnosed with cancer?

- You will be treated within the City or Counties Medical Provider Network (MPN) or third-party workers compensation administrator. Previous agreements between Cities and insurance agencies may differ.
- The MPN typically includes one or more healthcare facilities and contracted medical specialists outside of those networks.
- Exception: if you have a pre-designated physician, “physician of record,” on file with the Risk Management Department that was pre-designated before your diagnosis and claims date, you may seek care through that physician.

In the case of cancer, regardless of whether or not you have a pre-designation, if you have already started in a treatment regime outside the City or County’s MPN, you may be allowed to continue that treatment with that provider if you choose. You will not be required to switch to an MPN provider. Cases of skin cancer will be evaluated on a case-by-case basis.

Do I have to work and/or take leave time during my cancer treatment and recovery?

Only if the WC claim is accepted as a work-related illness. Otherwise, you are responsible to use your time off.

Typically, you will be put on 4850 time:

- 4850 time is the section of the Labor Code that provides police officers, firefighters, and other emergency responders with paid time off when ill or injured as a result of work. When using 4850 time, you are in what’s called Temporary Total Disability Status, meaning that you cannot work in any capacity.
- 4850 time is full pay without loss of salary for up to one year (100% of gross salary).

    - For firefighters, it is equivalent to 2912 hours.
- 4850 income is not taxable.
- Flex Benefits are not impacted on 4850 time.
- You will continue to make retirement contributions and accrue service credits.
- You will continue to accrue leave time.

What about light duty? Light duty is at the discretion of the organization and may vary from case to case.

During your treatment and recovery, you may, at some point be deemed well enough to participate in Light Duty. If you choose to accept Light Duty, your status will change from Temporary Total Disability Status/Temporary Partially Disabled to Light Duty Status. If you are offered appropriate Light Duty but choose not to accept the assignment, you must use your own leave time.

Light duty pay includes:

- An assignment consistent with your doctor's work restrictions.
- Full pay.
- Taxes withheld.
- Continue to accrue Annual Leave.
- Retirement contributions and service credit accrual continue.
- Time limits may apply.

What happens after one year when my 4850 time runs out?

If you have not recovered enough to return to light or full duty, you are eligible for one additional year of Temporary Total Disability (TTD) Benefit.

- Temporary Total Disability Benefit is different from Temporary Total Disability Status.
    - Temporary Total Disability Benefit is a benefit mandated by the State of California and paid by the City or County to injured workers. This benefit is used after exhausting 4850 time, and the Labor Code does provide the maximum non-consecutive time you can receive TTD up to 104 weeks over a 5-year period. This includes up to 12 months of 4850 time plus another 12 months or 52 weeks of TTD that can be used non-consecutively.
    - Temporary Total Disability Status simply means you are unable to work in any capacity. When using 4850 time or receiving Temporary Total Disability Benefits, you are in Temporary Total Disability Status.
- You will receive 2/3 of your gross pre-tax pay not to exceed the State maximum, which changes based on State calculations. Your Risk Management or Claim Management may provide additional information.
- For current regulations, visit:

- http://www.dir.ca.gov/dwc/WCFaqIW.html#5
- http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter5.pdf

Long-Term Disability after Temporary Total Disability Benefit exhausted or concurrently with Temporary Total Disability Benefit.

- It is a 12-month benefit; it cannot be extended.
- You will receive 70% of your basic bi-weekly pay.
- If you have dependents with health coverage, you are responsible for paying their portion of premiums out of pocket.
- Second-year Long Term Disability, no income, but eligible for COBRA.
- Flex benefits are paid during the first 12 months at the “employee only” Flexible Benefits Plan Rate.
- Federal and State taxes are withheld.
- No retirement contributions are made while on Long Term Disability.
- Do not accrue leave time.
- May be used to extend income an additional 12 months in succession after 4850 time, and Temporary Total Disability Benefits are exhausted if totally disabled as defined by the Long-Term Disability plan document.
- Total disability means an employee who is medically certified by a licensed physician as unable to perform any gainful employment for which the employee is or becomes reasonably fitted by education, training, or experience.
- Reasonable accommodations / interactive dialogue.

Long Term Disability may be used concurrently with Temporary Total Disability Benefits to:

- Bridge the gap between 2/3 Temporary Total Disability Benefits and 70% Long Term Disability pay.
- Pay or flex benefits at the “employee only” rate.
- It is important to note that Long Term Disability income is 12 months maximum, and the clock starts ticking when any portion of that benefit is used.

Explaining “Permanent and Stationary:”

At some point during your journey, you will likely be deemed “permanent and stationary” by your treating physician. This is a legal term utilized in the workers’ compensation process, which means that you have reached a medical plateau; according to your physician, you are not getting any worse or better.

Your physician, a Qualified Medical Examiner, or in some cases of attorney-represented employees, an Agreed Medical Evaluator may provide a medical report that will be used to rate your disability from 0% - 100% taking into account a multitude of factors, including:

- Your medical condition and diagnosis
- Date of injury
- Your age
- Occupation
- Disability rating

Disability Ratings:

- You have the right to disagree with your disability rating and have your case heard in front of a worker's compensation judge.
- You can also ask to have your medical report rated by the State Disability Evaluation Unit.
- Once a disability rating (level of impairment) is agreed upon, and all other issues, such as medical bills, back pay, reimbursements, and several other potential issues, your injury case/claim may be ready to be formally settled by either stipulations and award, compromise and release, and findings and order.

Stipulations and Awards (also known as "Stips"):

- Award is paid based on the State of California scheduled amounts, and they accrue biweekly based on state-determined rates.
- If your physician has determined that you will require future medical care, it will be provided for as long as needed.
- Once a Stipulation is entered, within 5 years from your date of injury, if you experience additional disability, you are eligible to file for additional disability benefits by filing a timely Petition for New and Further Disability with the Workers' Compensation Appeals Board (WCAB).

Compromise and Release:

- Agreements are entered into in limited circumstances and are optional on the part of the City or County and the employee, subject to approval by the Judge.
- One lump-sum payment: full and final settlement of all issues.
- Generally speaking, no future medical care and no ability to re-open your case. An exception would be that compromise and release may be issued, allowing for continuing future medical treatment. Example: buyout of remaining permanent disability allowing for continuing future medical treatment on certain agreed-upon body parts/regions.

Supporting a member who was delayed or denied WC for a presumptive cancer:

What if my cancer claim is delayed by my organization?

- It is possible that this can be avoided altogether by providing a cancer diagnosis

summary when submitting your worker's compensation-related documents. Claims will likely be delayed without a diagnosis.
    - Medical evidence via a cancer diagnosis summary from a treating physician indicating a causal link that the cancer is presumed to have developed or manifested itself and arose out of and in the course of employment as a firefighter. Absent this causal link, there may be a delay in making a liability determination.
- Ensure a summary of diagnosis information is included when you submit your paperwork.

What if my cancer claim is denied by the organization?

- After the department WC paperwork has been completed (DWC-1) and submitted, the organization has 75 days to investigate and decide (due to evidence that the cancer was caused by any other cause other than your occupation) if the diagnosis is work-related.
- While waiting for an acceptance form or denial, the injured worker can obtain limited treatment from a work comp doctor.
- If your WC claim is denied at the 75-day mark, you will be responsible for your time off for treatment (sick, personal leave, shift trades, or vacation).
- California law SB1127 (passed in January 2023) states that when liability has been unreasonably rejected for claims of injury and illness as defined in Sections 3212 to 3213.2, inclusive, the amount of the penalty shall be five times the amount of the benefits unreasonably delayed due to the rejection of liability, but in no case shall the penalty exceed fifty thousand dollars ($50,000). The question of rejection and the reasonableness of the cause shall be determined by the appeals board in accordance with the facts for this penalty phase; this may be a legal issue best handled by an attorney.
- If, after 75 days, your claim is denied, then the injured (or ill) worker will not have access to medical treatment in the worker's compensation system.
- The parties will begin the Qualified Medical Examiner (QME) process if the claim is denied. This allows an injured worker to be evaluated by a Qualified Medical Examiner. A QME is a neutral third party that will review medical records, perform an evaluation, and provide a report on whether the injury is work-related.

Alternative Dispute Resolution (ADR):

Labor Code section 3201.7 provides bargaining units that can negotiate with cities and / or counties a labor-management agreement for worker's compensation. This allows the bargaining units to create an alternative dispute resolution system. The goal of the ADR system is to expedite the resolution of disputes firefighters face in worker's compensation. The municipalities can save on the overtime spent on backfilling the vacant work positions due to occupational illness or injury. Importantly, the ADR system provides firefighters with a fast-track system to resolve worker compensation disputes.

Mental Health:

- Consider the mental health needs of your workers when they receive any cancer diagnosis or denial of WC benefits.
- You or a member is having to deal with a possibly life-threatening disease with unknown outcomes for the future and fight for their and their family's future.
- Offer peer support, chaplain assistance, or clinical help in the form of clinically and culturally competent clinical help.

General Statements regarding the information within this document:

- The information within this FAQ document is meant to serve as a template to build your own.
- The information within this document is meant to serve as general guidance and may not cover all your agency's specific procedures for navigating Worker's Compensation.
- We recommend building a relationship with your Workers Compensation Division to help streamline care for your members who have become ill and need immediate help.
- Third-party administrators are often used for utilization review. We understand that worker's compensation may be able to approve claims as the final step in the approval process.