General Claims Handling – California Workers Compensation, Self Insurance Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What document details the terms of medical treatment for an injured worker?

A. Claim Form

B. Treatment Authorization Request (TAR)

C. Benefit Payment Summary

D. Injury Report

2. What can estimates of future liability never be reduced by, unless there is an Order of Credit?

A. Employee contributions.

B. Amount of third-party recoveries.

C. Insurance premiums.

D. Legal fees.

3. How long must a self-insured administrator maintain the claim file?

A. Two years from the date of injury

B. Five years from the last provision of benefits

C. Three years from the date of settlement

D. Indefinitely, until the claim is closed

4. How many days does a physician have to submit a Doctor's First Report of Occupational Injury or Illness?

A. 3 days

B. 5 days

C. 7 days

D. 10 days

5. When encountering an occupation not listed in the schedule, what should you do?

A. Consult with the injured employee only

B. Determine basic functions and relate to a scheduled occupation

C. Refer to state guidelines only

D. File a claim immediately

6. What is the time limit for an injured worker to report their injury to their employer in California?

A. Generally 5 days from the date of injury

B. Generally 14 days from the date of injury

C. Generally 30 days from the date of injury

D. Generally 60 days from the date of injury

7. How many working days does an employer or insurance carrier have to provide an employee with a change of physician upon request?

A. 3 Working Days

B. 5 Working Days

C. 7 Working Days

D. 10 Working Days

8. What is the function of a Claims Administrator in workers' compensation?

A. To handle all workplace injuries without documentation

B. To manage the claims process and communication with injured workers

C. To provide legal advice to employers

D. To oversee the safety program within the company

9. What is the level of permanent disability for a 39-year-old baker with a knee injury precluding heavy lifting?

A. 10%

B. 15%

C. 22%

D. 30%

10. Prior to April 19, 2004, what was the limit of temporary disability (TD) payments?

A. 180 weeks

B. 240 weeks

C. 300 weeks

D. 365 weeks

Answers

1. B
2. B
3. B
4. B
5. B
6. C
7. B
8. B
9. C
10. B

Explanations

1. What document details the terms of medical treatment for an injured worker?

A. Claim Form

B. Treatment Authorization Request (TAR)

C. Benefit Payment Summary

D. Injury Report

The Treatment Authorization Request (TAR) is the correct answer because it specifically outlines the medical treatment that is being requested on behalf of an injured worker. This document serves as a formal request for prior authorization of medical services, ensuring that the care being proposed aligns with the worker's injury and the established treatment guidelines. The TAR includes details about the types of treatments sought, the duration, and any other specifics necessary to facilitate the approval process by the claims administrator or employer. It is essential for managing care efficiently and ensuring that injured workers receive timely and appropriate medical services. In contrast, the Claim Form is primarily used to initiate the workers' compensation claim process rather than detailing medical treatment. The Benefit Payment Summary provides information about the benefits awarded to the injured worker, and the Injury Report documents the incident and nature of the injury but does not address the treatment plan specifically. These documents serve important functions within the claims process but do not focus on the authorization of medical treatment as the TAR does.

2. What can estimates of future liability never be reduced by, unless there is an Order of Credit?

A. Employee contributions.

B. Amount of third-party recoveries.

C. Insurance premiums.

D. Legal fees.

Estimates of future liability are essential for accurately assessing the financial obligations associated with workers' compensation claims. They are projections of the costs that may arise over the life of a claim. In most scenarios, these estimates can be influenced or reduced by various factors, but the ability to offset them through certain sources is not always permissible without specific legal circumstances. Third-party recoveries refer to any funds that a worker might receive from a lawsuit against another party responsible for their injury, apart from their employer's workers' compensation liability. Unless there is an Order of Credit, meaning a legal directive allowing for the reduction of the employer's liability based on those third-party recoveries, the estimates of future liability must remain intact. This is crucial because it ensures that the workers' compensation system does not double indemnify the injured employee while also shielding the employer from being unfairly burdened. In contrast, employee contributions, insurance premiums, and legal fees may have distinct implications for claims but do not fall under the same restrictions regarding future liability estimates. Therefore, these types of deductions or adjustments are generally permissible without requiring an Order of Credit, distinguishing them fundamentally from third-party recoveries.

3. How long must a self-insured administrator maintain the claim file?

A. Two years from the date of injury

B. Five years from the last provision of benefits

C. Three years from the date of settlement

D. Indefinitely, until the claim is closed

The correct choice regarding how long a self-insured administrator must maintain the claim file is five years from the last provision of benefits. This timeframe is established to ensure that all necessary documentation related to the claim is available for review in case of any disputes or regulatory audits that may arise post-closure. Retaining the file for five years provides a sufficient period to address any potential inquiries related to benefits provided or to support the defense of claims should they arise. The importance of this timeframe is underscored by the fact that workers' compensation claims can sometimes take years to resolve completely, and issues may still need to be addressed long after the initial benefits have been dispensed. By ensuring that all related records and documents are kept for this duration, self-insured administrators comply with legal standards and facilitate a clear understanding of the claim history if necessary. The other options suggest shorter or indefinite durations, which do not align with the legal requirements set forth for maintaining such records. A duration of two years from the date of injury may not provide sufficient time for addressing all claim-related issues. A three-year period from the date of settlement also falls short, as benefits may continue beyond this timeframe or disputes may arise that justify longer retention. As for indefinite retention, while having access

4. How many days does a physician have to submit a Doctor's First Report of Occupational Injury or Illness?

A. 3 days

B. 5 days

C. 7 days

D. 10 days

A physician must submit a Doctor's First Report of Occupational Injury or Illness within 5 days of being aware of the injury or illness. This requirement ensures timely communication of essential medical information to both the employer and the claims administrator, facilitating prompt claims processing and appropriate medical care for the injured worker. While there are various timeframes in different contexts within workers' compensation, the 5-day window specifically aligns with California's regulations, emphasizing the importance of expediency in managing occupational injuries or illnesses. This regulatory framework supports the efficient handling of claims and helps ensure that injured workers receive necessary benefits and services without unnecessary delays.

5. When encountering an occupation not listed in the schedule, what should you do?

A. Consult with the injured employee only

B. Determine basic functions and relate to a scheduled occupation

C. Refer to state guidelines only

D. File a claim immediately

When encountering an occupation not listed in the Workers' Compensation schedule, determining the basic functions of that job and relating them to a scheduled occupation is the correct course of action. This process is essential because it allows for a better understanding of the job's characteristics and responsibilities, which can help in appropriately assessing the claim and determining the relevant benefits. By comparing the essential functions of the unlisted occupation to similar scheduled occupations, you can draw parallels that facilitate decisions about wage loss, medical treatment, and other pertinent aspects of the claim. This methodology ensures that there is a logical basis for handling claims related to lesser-known job roles, maintaining consistency and fairness in the claims process. In this context, consulting only with the injured employee might not provide the comprehensive information needed to make an informed decision. Relying solely on state guidelines without considering the specifics of the job could overlook critical details. Filing a claim immediately without this assessment could lead to misunderstandings and incorrect determinations regarding the compensation.

6. What is the time limit for an injured worker to report their injury to their employer in California?

A. Generally 5 days from the date of injury

B. Generally 14 days from the date of injury

C. Generally 30 days from the date of injury

D. Generally 60 days from the date of injury

In California, the time limit for an injured worker to report their injury to their employer is generally 30 days from the date of the injury. This reporting is essential for the injured worker to be eligible for benefits under the state's workers' compensation system. By notifying the employer within this time frame, the injured worker provides the employer with the opportunity to investigate the claim and facilitate the claims process. If an injured worker fails to report the injury within the 30-day timeframe, they may face challenges in receiving benefits, although there are circumstances under which late reporting may still be considered. This underscores the importance of prompt communication regarding workplace injuries, to ensure the worker's rights are preserved and the employer can take appropriate actions to address the situation. The other options do not align with the established requirements under California law. Reporting deadlines shorter than 30 days may not allow adequate time for the worker to assess the injury and determine its implications. Conversely, deadlines longer than 30 days could complicate the claims process and potentially jeopardize the worker's eligibility for benefits.

7. How many working days does an employer or insurance carrier have to provide an employee with a change of physician upon request?

A. 3 Working Days

B. 5 Working Days

C. 7 Working Days

D. 10 Working Days

In California workers' compensation, when an employee requests a change of physician, the employer or insurance carrier is required to provide that change within a specified time frame to ensure that the employee receives appropriate medical care without unnecessary delays. The correct answer indicates that they must fulfill this request within 5 working days. This requirement helps to facilitate timely medical treatment and aligns with the goal of maintaining the employee's health and ability to return to work. Options that suggest fewer or more days, such as 3, 7, or 10 working days, do not align with California's regulatory framework, which is specifically designed to protect the rights of injured workers while ensuring that employers and insurers comply with procedural standards. Providing a change of physician within 5 working days strikes a balance between operational efficiency and the need for prompt medical attention, which is crucial in managing workers' compensation cases effectively.

8. What is the function of a Claims Administrator in workers' compensation?

A. To handle all workplace injuries without documentation

B. To manage the claims process and communication with injured workers

C. To provide legal advice to employers

D. To oversee the safety program within the company

The function of a Claims Administrator in workers' compensation involves managing the entire claims process, which includes communication with injured workers. This role is crucial as it ensures that claims are processed efficiently and that workers receive the support and information they need regarding their injuries and benefits. The Claims Administrator coordinates with healthcare providers, manages documentation required for claims, and ensures compliance with regulations and policies surrounding workers' compensation. Handling workplace injuries without documentation, providing legal advice, or overseeing safety programs fall outside the direct responsibilities of the Claims Administrator. While safety programs and legal advice are important elements of workers' compensation and workplace safety, they are typically managed by different roles within an organization, showing the specialized focus of the Claims Administrator on claims management and communication.

9. What is the level of permanent disability for a 39-year-old baker with a knee injury precluding heavy lifting?

A. 10%

B. 15%

C. 22%

D. 30%

The level of permanent disability for a 39-year-old baker with a knee injury preventing heavy lifting is evaluated based on several factors, including the nature of the job, the impact of the injury on the individual's earning capacity, and the established guidelines for disability ratings in California workers' compensation cases. In this scenario, the fact that the individual is a baker, a profession that may require standing for long periods and performing physical activities such as lifting, plays a significant role. Since the knee injury specifically prevents heavy lifting, it suggests a substantial limitation on the individual's ability to perform essential job functions, which is critical in determining the degree of permanent disability. A rating of 22% may be consistent with the significant restrictions imposed by the knee injury compared to a lower percentage, which would indicate a mild disability or one that does not substantially impact the worker's ability to perform essential job duties. In California, the rating guidelines consider both the specific body part injured and the occupation of the injured worker, leading to a higher percentage for injuries that severely impact employment capabilities. This understanding of how permanent disability is rated, especially in relation to the type of work the individual performs, substantiates why a 22% rating is appropriate for this case, reflecting a notable impairment

10. Prior to April 19, 2004, what was the limit of temporary disability (TD) payments?

A. 180 weeks

B. 240 weeks

C. 300 weeks

D. 365 weeks

Prior to April 19, 2004, the limit for temporary disability (TD) payments in California workers' compensation was set at 240 weeks. This means that an injured worker could receive TD benefits for up to 240 weeks, or approximately five years, depending on the nature and extent of their disability. The purpose of TD payments is to provide financial support to employees who are temporarily unable to work due to a work-related injury or illness, allowing them to focus on their recovery without the immediate pressure of financial instability. Recognizing the importance of providing adequate support while maintaining a balance with the insurance system's sustainability, this limit was established to ensure that the process remained fair for both employees and employers. After April 19, 2004, this limit was revised to 104 weeks, reflecting changes in the workers' compensation laws aimed at promoting quicker rehabilitation and return to work for injured workers. This historical context is essential for understanding the evolution of TD benefits within California's workers' compensation system and the legislative intent behind these changes.