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QUESTIONS AND ANSWERS

"ANSWERS TO YOUR TOP TEN BURNING WORKERS' COMPENSATION QUESTIONS"

MEET MULLEN & FILIPPI'S NEW MANAGEMENT COMMITTEE AND TRY TO STUMP THEM WITH YOUR BEST WORKERS' COMPENSATION QUESTIONS. LEARN NEW WAYS TO HANDLE RE-OCCURRING COMMON ISSUES AND BRING YOUR OWN QUESTIONS FOR ON THE SPOT DISCUSSIONS.

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MULLEN & FILIPPI, LLP
SEPTEMBER 2010

QUESTION

What is the impact of the recent Guzman decision on my cases?

ANSWER

Milpitas Unified School District v. WCAB (Guzman) 8/19/10 Court of Appeal, Sixth Appellate District H034853
Affirmed the WCAB en banc decision that the PDRS and AMA Guides are rebuttable – to accommodate "complex or extraordinary cases."
How does one define "complex or extraordinary"? This seems to be a revision of the "fairness" test.
The physician must utilize the "four corners of the Guides."
Physician must exercise "clinical judgment to evaluate impairment most accurately."
What if clinical judgment conflicts with criteria for rating impairments as set forth in the Guides?
Any deviation must be supported by "substantial evidence."
The "decision does not allow a physician to conduct a fishing expedition through the Guides 'simply to achieve a desired result'; the physician's medical opinion 'must constitute substantial evidence' of WPI and…must set forth the facts and reasoning (that) justify it. In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability…"

See also MacNeil v. Petaluma City Jr High School District (2010) 38 CWCR 88. WCAB panel denied Recon of WCJ's award of PD for a shoulder disability based upon a PD rating calculated by analogy to partial amputation.

Practical tips:
"Guzman" ratings are going to become even more prevalent. Familiarity with AMA Guides is essential to check to see whether the rating given by the physician "matches up" with the diagnosis in your case and with the criteria for rating the condition as set for in the applicable text of the Guides. (Don't just read the charts used by the doctor; read the text instructions for those charts.) On a case by case basis a private consultative rating may be of assistance to form the basis for a request for a supplemental report. (Watch out, if the report of the rating consultant is sent to the AME/QME it must be served on the applicant/applicant's attorney, and keep in mind that the consultant's report itself is inadmissible) On a case by case basis, a deposition of the AME/QME may be needed.

QUESTION

What is the last day I can make an Offer of Regular Work or an Offer of Modified or Alternative Work in order to get the 15% bump down?

Does the 15% increase apply if I don't make the offer but the injured worker continues working for the employer, or returns to work for the employer after TD ends?

Is there any difference between those two?

ANSWER

This is addressed in L.C. 4658(d)(2) and L.C. 4658 (d)(3)(A), which says that if w/i 60 days of P & S status, the defendant does not offer the applicant reg, mod or alt work, each PD payment remaining, shall be increased by 15%, but if an offer is made, each remaining PD payment from the date of the offer, shall be decreased by 15%.

This has been interpreted to mean 60 days from the defendant's RECEIPT of the PD report. (Audiss v. City of Rohnert Park (2007) 35 CWCR 123 (Order Granting Recon and Decision after Recon).) So date stamp the med-legal or treater P & S report, and mail your Notice of Offer on the required form (DWC AD 10118 or DWC AD 10133.53) to applicant w/i 60 days of when you get the report.

Practice Tip: In order to make your Offer, the P & S report must either confirm applicant can return to his U & C job, or state what work restrictions the applicant has. If this is not in the P & S report, you should immediately get clarification from the doctor. Otherwise, it's impossible to know what modified or alternative job, can be offered.

Further, the 15% provision does NOT apply if the applicant lost no time for the injury. (Tsuchiya vs. County of L.A. (2009) Case # ADJ 2508984 (WCAB opinion & decision after Recon--panel decision).)

Finally, even if the applicant returns to his or her usual and customary job after TD ends, the 15% bump up will apply unless you timely issue the Notice of *Regular* Work. Yes, that's not fair. And always make sure your notice is correctly filled out, w/ a salary of at least 85% of wages at DOI, the job lasts at least 1 year and is w/i reasonable commuting distance, and there is a job description, and serve on applicant w/ proof of service.

QUESTION

When does the 104 week cap on TD run in post 4/19/04 cases?

Post 1/1/08 cases?

What if there is more than one injury causing TD?

ANSWER

LC 4656(c)(1) Aggregate disability payments for a single injury occurring on or after 4/19/04, causing temporary disability shall not extend for more than 104 compensable weeks within a period of 2 years FROM THE DATE OF COMMENCEMENT OF TD PAYMENT.

LC 4656(c)(2) Aggregate disability payments for a single injury occurring on or after 1/1/08 causing temporary disability SHALL NOT EXTEND FOR MORE THAN 104 COMPENSABLE WEEKS within a period of 5 years from the date of injury.
(The "date of commencement" phrase has been removed.)

WHEN DOES THE CAP START TO RUN IN POST 4/19/04 CLAIM?
See Hawkins v. SCIF (2007) 72 CCC 807 (en banc) The cap started to run only as of the date of the actual initial payment of TD.

PAYMENT OF TEMPORARY PARTIAL DISABILITY COUNTS TOWARD THE CAP.
See Harris-Boyd v. Northwest Airlines, Inc (2010) WCAB panel ADJ2608381. 3/05 injury originally filed in Michigan. Temporary partial disability benefits were paid in Michigan. Michigan case withdrawn and CA case filed. The temp partial payments counted toward the 104 week cap

LC 4850 BENEFITS PAID TO SAFETY MEMBERS DO NOT COUNT TOWARD THE CAP
See City of Oakland v. WCAB (Aisthorpe/Watson) (2007) 72 CCC 249 (writ den); City of Long Beach v. WCAB (Weber) (2007) 72 CCC 837 (writ den); County of Sacramento V. WCAB (Taylor) (2007) 72 CCC 854 (writ Den); City and County of San Francisco v. WCAB (Bryant) (2207) 72 CCC 1013 (writ den).

BUT SALARY CONTINUATION PAID TO A STATE EMPLOYEE DOES COUNT TOWARD THE CAP.
See Medearis v. WCAB, County of LA (2008) 73 CCC 1111 (Court of Appeal). Case involved a hospital central services technician.

IDL PAYMENTS DO COUNT TOWARD THE CAP
Brooks v. Calif State Dept of Corrections (2008) 73 CCC 447 (Court of Appeal; Seidman v. WCAB/Dept of Parks & Recreation and SCIF (2007) 72 CCC 1530 (writ den). Industrial Disability Leave and Enhanced IDL Benefits paid to State employees in lieu of TD do count toward the cap.

ED CODE BENEFITS PAID TO SCHOOL DISTRICT EMPLOYEES DO COUNT TOWARD THE CAP
See Mount Diablo Unified School District v. WCAB (Rollick) (2008) 73 CCC 1212 (Court of Appeal)

COMPENSABLE CONSEQUENCE CONDITIONS ARE LIMITED BY THE CAP OF THE UNDERLYING INJURY
See Divjakinja v. WCAB, SCIF (2008) 73 CCC 142 (writ den) A compensable consequence condition causing a period of TD beyond the original 104 weeks for the underlying injury did not result in additional liability for TD despite surgery for the compensable consequence condition where the cap had run for the underlying injury.

CONCURRENT PERIODS OF TD:
See Foster v. WCAB (2008) 73 CCC 466 (Court of Appeal); Vasquez v. WCAB, City of Pasadena (2008) 73 CCC 727 (writ den). 2 injuries close in time which cause TD only after the 2nd injury – the cap for the 2 injuries runs concurrently; applicant does not get successive caps.

SUCCESSIVE INJURIES CAUSING SEPARATE CAPS:
See Rasura v. WCAB (2009) 38 CWCR 44. Board panel affirmed WCJ's award of TD for a subsequent injury that took place 2 years after a prior injury for which intermittent TD payments had been made. The 104 week limit on TD for the 2nd injury did not begin to run when TD was paid for the 1st injury. The injuries were sufficiently separated by time that it was found the 2nd injury caused a new period of TD subject to its own cap. (Practice tip: While establishing separate injuries may result in additional liability for TD, Benson ratings may have a beneficial impact on PD value.)

DOES PAYMENT OF 1 DAY OF TD START THE CAP?
See Najjar v. Meeks Building Center (2010) WCAB Panel ADJ4254212: ADJ3933016. TD for attending an AME/QME does not qualify as a payment of TD to start the cap running.

But see Morris v. WCAB, New United Motors Manufacturing admin by Gallagher Bassett Services, Inc (2009) 74 CCC 794 (writ den). 1 day of TD was paid after a 3 day waiting period in 2005. Applicant was not entitled to further TD when he underwent surgery in 2008 because it was held the cap had run.

EXCEPTIONS TO THE 104 WEEK CAP LC 4656(c)(3)
Aggregate disability payments shall not extend for more than 240 compensable weeks within a period of 5 years from the date of injury:

(A) Acute and chronic hepatitis B
(B) Acute and chronic hepatitis C
(C) Amputations
(D) Severe burns
(E) HIV
(F) High-velocity eye injuries
(G) Chemical burns to the eyes

(H) Pulmonary fibrosis
(I) Chronic lung disease

What is an "amputation" for purposes to the 104 cap exception?
Back surgery is NOT. The injury/treatment for the industrial injury must result in removal or partial removal of an "appendage." Cruz v. Mercedes-Benz of San Francisco, Intercare (2007) 72 CCC 1281 (WCAB en banc).
Total knee removal and replacement surgery is NOT. Ramirez v. WCAB, State Dept of Corrections (2008) 73 CCC 1120 (writ den).

But see Collinwood v. Wausau Ins (2009) 38 CWCR 10. Industrial injury that caused rupture of breast implant and necessitated multiple corrective surgeries was held to constitute an "amputation" for purposes of the statute.

QUESTION

What happens if I pay retroactive TD to an applicant and there is a notice of a lien from EDD?

What if I commence PDA's to an applicant?

ANSWER

If you pay retroactive TD to an applicant and you had notice of EDD payments during this same period, you will have to pay EDD also. Again, it's not fair, as applicant will be double paid by you and EDD. But this is covered by L.C. 4904, which gives EDD the right to be reimbursed for the amount of benefits they paid, for the same days of TD or PD the applicant is entitled to. EDD will take the position that if the defendant was put on notice (either verbal or written) that EDD was paying, then if we issue retroactive TD or PD, it should go to EDD, NOT the applicant. So before you issue any large sums for retro TD or PD, call or fax EDD to make sure they did not pay for that time frame.

When we have notice of EDD's involvement, L.C. 4904 also requires us to notify EDD in writing w/i 15 working days after our indemnity payments begin.

L.C. 4904 is also why it's important to avoid finalizing stips or a C & R w/ an applicant, where you are giving an applicant a "hold harmless clause" on EDD's lien. If you pay applicant all the PD in a C & R, you may have to pay it again to EDD. There are limited reasons you may need to wait to settle EDD's lien, but if that's the case, then if possible, get a Thomas finding for negotiating purposes w/ EDD.

QUESTION

What are the most common ways for an applicant attorney to get a panel QME report deemed inadmissible?

ANSWER

The most common way an applicant's attorney will try to get a PQME report deemed inadmissible, is by alleging the adjustor did not follow L.C. 4062.3(a)(2)(b), which requires that you serve the applicant w/ all "information" you plan on sending the PQME, no later than 20 days before you provide it to the PQME. Further, Reg 35(a) requires you to serve the med records and non-med records, and a letter to the PQME outlining the issues, and a log of what records are being sent, and the DEU 100 form (Employee's Disability Questionaire) and mandatory language from Reg 35(c): "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days." All of this should be sent w/ a proof of service on the applicant.

Further, L.C. 4062.3(e) requires that all communication w/ the PQME be served on the applicant 20 days in advance of the eval, and that any subsequent communication be in writing and also served on the applicant when sent to the PQME. If you violate this, L.C. 4062.3(f) allows the applicant to get a new eval and you may be subject to contempt charges and costs. Reg 35(k) says that if there is ex parte communication w/ the PQME, applicant is allowed a whole new panel list to select a new PQME.

Also, L.C. 4062.5 and L.C. 139.2(j) (1) say if the PQME fails to issue their report w/i 30 days of the eval, the report can be deemed inadmissible too. But if the parties wait to see the untimely report, that object may be deemed waived.

QUESTION

When can I request a panel QME replacement and what is the procedure?

ANSWER

A Reasons for Replacement:

(1) The QME does not practice in the required specialty.

(2) The QME cannot schedule the appointment timely.
  (a) Within 60 days of the initial request for appointment, or
  (b) Within 90 days of the initial request for appointment if the 60 day limitation is waived by the party entitled to make the appointment.

(3) The injured worker has changed residence between the date of the issuance of the panel and the date of the initial evaluation.

(4) A doctor on the list is a member of the same group practice as another doctor on the list. See Labor Code §139.3 for the definition of membership in the "same group practice."

(5) The QME is unavailable as defined in Administrative Rule §33. (AR §33 allows a doctor to request temporary "unavailable" status from the Medical Director.)

(6) The QME is no longer available for a subsequent evaluation.

(7) A QME on panel is currently or has been the employee's treating physician.

(8) The parties agree to a panel within the geographic area of the applicant's work place.

(9) The Medical Director, upon written request, finds good cause that a replacement QME or a replacement panel is appropriate for reasons related to the medical nature of the injury. Good cause for purposes of this section is defined as a documented medical or psychological impairment.

(10) The Medical Director, upon written request, determines the chosen specialty is inappropriate for the disputed medical issues.
  (a) The objecting party must attach the most recent medical report and a copy of the Doctor's First Report of Injury.
  (b) The Medical Director can then request either party to provide additional information or records necessary for the determination.

(11) The Panel QME fails to follow the procedures of Administrative Rule §34 regarding the notification or cancellation of the appointment.
   (a) The Panel QME has 5 days from the date the appointment is made to serve the QME Appointment Notification Form on the applicant and the claims administrator
   (b) The request for the replacement must be made within 15 days from the date the party became aware of the violation or the date the report was served by the evaluator, whichever is earlier.

(12) The Panel QME fails to meet the deadlines of Labor Code §4062.5 and Administrative Rule §38.
   (a) Panel QME must report within 30 days after an evaluation.
   (b) Panel QME must issue a supplemental report within 60 days after the request.
   (c) A Panel QME can request an extension of these time limits. See Administrative Rule §38 for the details.
   (d) The party requesting the replacement must object to the late report prior to the date of service of the report.

(13) The Panel QME has a disqualifying conflict of interest as defined in Administrative Rule §41.5. Examples of such conflicts of interest are:
   (a) The Panel QME has a family relationship with one of the parties.
   (b) The Panel QME has a financial relationship with one of the parties.

(14) The Administrative Director orders a new Panel QME pursuant to Administrative Rule §10164(c)

(15) The Panel QME refuses to provide a complete medical evaluation or report.

(16) The applicant has not seen any of the doctors on the panel QME list that had issued over 24 months previously.

(17) There has been an ex parte communication with the Panel QME. See Administrative Rule §35(f) and Labor Code §4062.3(f).

B Procedure for Obtaining Replacement Panel or Panel QME

(1) The Medical Unit allows parties to call the Unit directly to request a replacement panel. Telephone number: (510) 286-3700 or (800) 794-6900.
   (a) Nothing in the rules requires the Medical Unit to do so this.
   (b) This is an ex parte communication.
   (c) Sometimes it is hard to get through to a representative.

(2) A party can use QME form 31.5
   (a) It is optional.

(b) It is tailored for requesting a replacement panel and includes a list of the reasons for replacement.

(c) The form reminds the party what additional information must be attached to the request.

(3) A party can use modified QME form 105 or 106.

(a) It is difficult to modify the form.

(b) It is confusing to the Medical Unit.

(4) A party probably can make a request for panel by petition or letter.

(5) The Medical Unit can replace either the doctor on the panel or issue a new panel.

(a) The Medical Unit must issue a new panel if any of the doctors on the original panel have already been stricken by one of the parties.

Disclaimer – This is intended to be a checklist and is not a full explanation of the law. When analyzing an issue related to replacement panels, the claims representative should check the statutes and administrative rules for details and exceptions or consult with an attorney.

QUESTION

What is the procedure and timing re the 2nd opinion spinal surgery evaluation?

ANSWER

(1) Submit for Utilization Review pursuant to Labor Code §4610
- (a) The UR decision must be made timely.
  - (i) Within 5 days from receipt of request and information reasonably necessary to make the determination – Labor Code §4610(g).
  - (ii) In no case more than 14 days from the date of the medical treatment request by the treating physician – Labor Code §4610(g).
  - (iii) Within 10 days of request by treating physician so defendant can make a timely objection to spinal surgery recommendation – Cervantes v. Aguila Food Products, Inc. 74 CCC 1336 (WCAB *en banc*, 2009), 75 CCC 904 (writ denied, 8/4/10) – Defendants filed a Petition for Review with the California Supreme Court on 8/13/10.
- (b) If UR certifies the surgery, then provide the surgery
- (c) If UR is not done timely, then:
  - (i) Shake your fists and curse the *Cervantes* decision, and
  - (ii) Provide the surgery.

(2) If UR timely issues a non-certification of surgery, then file a DWC Form 233-Objection to Treating Physician's Recommendation for Spinal Surgery.
- (a) The objection must be filed within 10 days from the date of receipt of the treating physician's report containing the recommendation.
  - (i) If not done within the time limit, provide the surgery.
- (b) File the original with the Administrative Director – Medical Unit at the address listed on the instructions to the form.
- (c) Serve the Objection on the applicant, the applicant's attorney and the treating physician.
- (d) The DWC Form 233 must comply with the following:
  - (i) The treating physician's report recommending the surgery must be attached to the form.
  - (ii) The form must be signed by an employee of the employer, the insurance carrier or the claims administrator. The defense attorney may not sign and submit the form.
  - (iii) The form must be postmarked no later than 10 days after the date of receipt of the treating physician's report recommending the surgery.

QUESTION

Can I get apportionment in an AMA Guides case for a PD award under the 1997 rating schedule involving the same body part?

What do I need to do?

ANSWER

Remember, defendant has the burden of proof to establish apportionment through substantial evidence. The existence of a prior award of PD under the old rating schedule was not sufficient to result in apportionment even though the later injury involved the same part of the body. See Minvielle v. County of Contra Costa (2010) 38 CWCR 7.
WCAB panel held that LC 4664 apportionment is inapplicable when the injuries are rated under different schedules and overlap cannot be shown.
This was a WCAB panel decision in which the WCJ had originally found apportionment, as the AME had considered the question of overlap and had provided ratings for both injuries under the new and old schedule. The WCAB rescinded that decision on applicant's Recon and remanded the case for further development of the record. Eventually the WCJ issued another decision which turned on the fact that there was no evidence of LC 4663 apportionment. Note, defendant did request Supreme Court review of this decision.

Practice tip: Don't simply rely on LC 4664 (b) which says, "If the applicant has received a prior award of PD, it shall be conclusively presumed that the prior PD exists at the time of any subsequent industrial injury..." Look to LC 4664 (a), "The employer shall only be liable for the percentage of PD directly caused by the injury AOE/COE." And especially LC 4663 (a), "Apportionment of PD shall be based on causation"; 4663(c) requiring the physician to make an apportionment determination by finding the approximate percentage of PD caused by the direct result of the injury and the approximate percentage of PD caused by other factors both before and subsequent to the industrial injury, INCLUDING PRIOR INDUSTRIAL INJURIES. Don't forget to ask the physician to explain in detail HOW and WHY apportionment under LC 4663 is medically reasonable.

What about apportionment for an injury pending on a Petition to Reopen?
See Hartfield v. LA Unified School District (2009) 37 CWCR 255 (WCAB panel). Original award was 45%. Petition to Reopen filed. Both QMEs found some apportionment. WCAB issued award of 64% without any apportionment. Defendant lost its Recon. Held, no apportionment since the doctors did not distinguish between apportionment of PD in the original award and only the increase in PD. Referred to Vargas v. Atascadero State Hospital (2006) 71 CCC 500 (WCAB en banc) which held apportionment can only apply to new and further PD and cannot be used to revisit the original award.

QUESTION

Do I have any defenses against those alleged sleep disturbance claims?

ANSWER

In Manuela Pena vs. Alvarado Hospital (Board Panel Decision, SDO348708, March 28, 2008), a Board Panel found that sleep difficulties caused by pain from an orthopedic injury could not be rated as a sleep disorder under Table 13-4 in the AMA Guides. A Board Panel decision is not binding precedent, although it may be cited to the Workers' Compensation Appeals Board. It is an indication of how at least three of the commissioners have ruled on the issue and can be used in arguments before other judges, especially to show the reasoning of the decision.

In §13.3(c), the guides indicate that impairment from sleep disorders relate to a series of conditions which involve the nervous system, mental factors, cardiovascular system, hematopoietic system and respiratory system including sleep apnea. There is no mention of sleep disturbances related to pain resulting from orthopedic conditions. The section only discusses neurological conditions. See page 317 of the AMA Guides.

On page 4, in Table 1-2, the guides list the activities of daily living which are measured by the impairment figures found in the guides. Sleep is included as one of these activities of daily living.

It is clear from these two sections that the AMA Guides do not intend for the sleep disorder impairments to apply to sleep difficulties resulting from the pain from an orthopedic condition.

QUESTION

What is the best way to get my mailed in Stipulations or C & R approved without getting an Order Suspending or having it set for an adequacy hearing?

ANSWER

To avoid getting an Order Suspending Action on your C & R or stips, make sure you file ALL the necessary documents. These should include the fully signed settlement document, the treater and PQME reports (or notice to applicant of their PQME rights), benefits print-out, wage statement (if not a max earner), a rating (DEU or independent rating or even your own rating--preferably also put in your settlement papers), the Notice of Offer of Reg or Mod Work, resolution of all liens, and L.C. 4906(g) declaration, AND hopefully a letter explaining the basis of your settlement. (See attached Order Suspending, on the common items defendants fail to submit w/ their settlement papers.)

Reg 10882 allows a judge to set the case for adequacy of the proposed settlement. Make the judge's job as easy as possible and explain why this is an adequate settlement. Emphasize things like no lost time, little past med care, limited future med care, the low PD rating, the RTW, etc. A little extra time by you, will often result in a quick Order of Approval, instead of an adequacy hearing.

Since settlement is usually the end of the case, we've also come to the end of our discussion. Good luck!

STATE OF CALIFORNIA
Division of Workers' Compensation
Workers' Compensation Appeals Board

Applicant,
vs.

Defendant.

Case No.

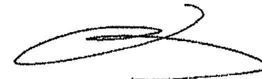
ORDER SUSPENDING ACTION

The above document is on file herein. Approval thereof will be stayed and will be considered again only after the additional information requested below has been filed or the required action taken. In the absence of response from the parties within twenty (20) days from the date hereof, this matter will be:

☐ Taken off calendar without further Order of this District Office
☒ Set for conference

Action has been suspended for the following reason(s):

☐ 1. Document not executed by: ☐ Defense counsel/representative ☐ Applicant ☐ Applicant's attorney ☐ Document not properly witnessed or notarized.
☐ 2. A copy of the ☐ C&R ☐ Stips ☐ Medicals ☐ Petition ☐ ________ must be served upon: ☐ E.D.D. ☐ Applicant ☐ Applicant's attorney ☐ Lien Claimant(s) ☐ __________
☐ 3. Provision must be made for disposition of bill(s)/lien(s) of: ☐ E.D.D. ☐ ___________ ☐ Affidavit of Defendant Re: Resolution of Liens
☐ 4. The District Offices file contains no: ☐ treating medicals ☐ AME/QME medicals ☐ permanent and stationary reports ☐ ____________
☐ 5. Provide detailed information as to: ☐ temporary disability benefits paid ☐ __________
☐ 6. Submit all evidence and arguments in support of: ☐ request for Thomas finding ☐ requested attorney's fees
☐ 7. Defendant's medicals do not support a Thomas finding. Does defendant withdraw the request for such finding?
☐ 8. The District Offices file contains no Labor Code § 4906(g) statement of: ☐ Employee ☐ Insurer ☐ Employer ☐ Attorney for Applicant ☐ Attorney for Defense
x 9. Defendant to file documentation that applicant was advised of right to panel Qualified Medical Examiner at defendant's expense (Labor Code § 4061/§ 4062).
☐ 10. The language contained on page , paragraph is inappropriate. Does defendant agree to withdraw this language?
☐ 11. Please explain basis for settlement.
X 12. Other: Provide rating of permanent and stationary report. Apportionment questionable.



DATE: 06/01/2010

Lilla Rados
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE

Document ID: