

# California Workers' Compensation Permanent Disability and Permanent Disability Advance Payment Obligations: A Legal Analysis

## (PART-A INJURED WORKERS ANALYSIS)

February 27, 2026

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# CALIFORNIA WORKERS' COMPENSATION: PERMANENT DISABILITY BENEFITS AND ADVANCE PAYMENTS

Date: February 27, 2026

If you were hurt at work in California and your injury left you with a lasting health problem, you may be owed money called Permanent Disability (PD) benefits. This report explains how those benefits work, how they are calculated, when you should receive payment, and what you can do if your insurance company does not pay you correctly or on time.

This report also explains a related but different type of payment called a Permanent Disability Advance (PDA)—a lump-sum payment you can ask for before your final disability rating is decided.

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## Part 1: The Laws That Protect You

This section covers the main California laws that give you the right to permanent disability benefits.

### California Labor Code § 4650 — When Payments Must Start

The most important timing rule is found in Cal. Lab. Code § 4650 (<https://law.justia.com/codes/california/2005/lab/4650-4664.html>). This law says your employer's insurance company must make your first PD payment within 14 days after your last temporary disability payment ends. After that, payments must continue every two weeks (biweekly). If any payment is late, the insurance company must automatically add 10 percent to the late payment—you do not need to ask for this penalty.

### California Labor Code § 4658 — How Benefits Are Calculated

Cal. Lab. Code § 4658 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74658-permanent-disability-ratings-and-payments/>) sets out the method for calculating your PD payments. The law uses your disability rating percentage (how much your injury affects your ability to work) and multiplies it by a set number of weeks to determine how long you will receive payments. Each weekly payment is based on your wages before the injury, with minimum and maximum limits set by law.

***Important: If you do not return to work within 60 days after your temporary disability ends and your employer does not offer you suitable work, your weekly PD payment automatically increases by 15 percent. If your employer offers you suitable work and you turn it down, your payment decreases by 15 percent.***

### California Labor Code § 4660 — How Your Disability Rating Is Determined

Cal. Lab. Code § 4660 (<https://www.dir.ca.gov/dwc/pdr.pdf>) requires that disability ratings be fair, consistent, and objective. Your rating is based on the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition—a medical handbook doctors use to measure how much your injury affects your body. Your rating is then adjusted based on your age and occupation at the time of your injury.

### California Labor Code § 4662 — When You Are Considered Totally Disabled

Cal. Lab. Code § 4662 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4662/>) lists four injuries that the law automatically treats as permanent total disability (meaning 100% disabled for life):

- Loss of both eyes or eyesight
- Loss of both hands or use of both hands
- An injury causing near-total paralysis
- A brain injury causing permanent mental incapacity

If you have one of these injuries, you receive PD benefits for life at the temporary disability rate, with yearly increases to keep up with rising wages.

## California Labor Code § 4664 — Limits on Accumulated Disability Awards

Cal. Lab. Code § 4664 (<https://www.sullivanattorneys.com/blog/understanding-accumulation-of-permanent-disability-under-lc-4664>) prevents your total PD awards from adding up to more than 100 percent for any single body region over your lifetime (unless you qualify for the automatic total disability categories listed above). The law divides the body into eight regions, including hearing, vision, upper extremities, lower extremities, and others.

## California Code of Regulations Title 8, § 10111.2 — Penalty Schedules

Cal. Code Regs. tit. 8, § 10111.2 ([https://www.dir.ca.gov/t8/10111\\_2.html](https://www.dir.ca.gov/t8/10111_2.html)) lists the specific dollar penalties insurance companies must pay when they fail to follow the rules. Penalties range from \$400 for up to six weeks of unpaid benefits to \$5,000 for more than 42 days of unpaid benefits.

## California Code of Regulations Title 8, § 10117 — Employer Work Offers

Cal. Code Regs. tit. 8, § 10117 (<https://www.dir.ca.gov/t8/10117.html>) requires your employer to offer you regular, modified, or alternative work within 60 calendar days after your condition becomes permanent and stationary. If the employer fails to do this, your PD payments go up by 15 percent. The offered work must be within a reasonable commuting distance from your home.

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## Part 2: 2026 Benefit Rates and Recent Changes

This section explains the current benefit rates and important legal developments that affect your claim.

### 2026 Benefit Rates

On November 21, 2025, the Division of Workers' Compensation (DWC) announced new benefit rates (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>) effective January 1, 2026. The rates changed because California's State Average Weekly Wage (SAWW) increased by 4.99 percent.

Benefit Type	2025 Rate	2026 Rate
Minimum Temporary Total Disability (TTD)	\$252.03/week	\$264.61/week
Maximum TTD	\$1,680.29/week	\$1,764.11/week
Minimum Permanent Disability (PD)	\$160/week	\$160/week
Maximum PD	\$290/week	\$290/week
Mileage Reimbursement	\$0.70/mile	\$0.725/mile

**Note: The PD minimum and maximum rates of \$160 and \$290 per week are set by law for all injuries on or after January 1, 2014. They do not change with the annual wage adjustment. The TTD rates do change every year.**

### The Stranak Decision — A Recent Win for Injured Workers

In *Stranak v. City of Los Angeles*, 2024 Cal. Wrk. Comp. P.D. LEXIS 179, the Workers' Compensation Appeals Board (WCAB) made an important ruling that helps injured workers. The WCAB is the state body that reviews disputes about workers' compensation benefits.

The Stranak decision established these rules:

- The employer (not the worker) must prove that a prior disability and a current disability affect the same body region before reducing your benefits through apportionment (splitting your disability between work and non-work causes).
- If your disability affects more than one body region, you have the right to assign it to whichever region gives you the highest rating.
- The employer must present actual medical evidence—they cannot simply point to an older award and automatically reduce your current benefits.

This ruling makes it harder for insurance companies to cut your benefits by claiming your disability was partly caused by something other than your work injury.

### How the Annual Wage Adjustment Works

The DWC calculates new benefit rates each year using this method:

1. The state measures the average weekly wage of all California workers over 12 months
2. The percentage increase in that average is applied to the prior year's benefit rates
3. New minimum and maximum rates take effect on January 1

For 2026, the SAWW rose from \$1,704 to \$1,789 (an increase of \$85, or 4.99%). This raised TTD rates but did not change the fixed PD rate range of \$160–\$290 per week.

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## Part 3: Who Qualifies for Permanent Disability Benefits

This section explains what must be true before you can receive PD benefits.

### What Is Permanent Disability?

Permanent disability means any lasting health problem from a work injury that reduces your ability to earn a living. Unlike temporary disability benefits (which you receive while you are recovering and expected to get better), PD benefits recognize that your condition will not fully improve. You can receive PD benefits even if you return to work (<https://legalaidatwork.org/factsheet/workers-compensation-permanent-disability-benefits/>), because the payment is for your reduced earning ability—not just for lost wages.

The law recognizes two levels of permanent disability:

- Permanent Partial Disability (PPD) — Your disability rating is between 1% and 99%. You receive payments for a set number of weeks based on your rating.
- Permanent Total Disability (PTD) — Your disability rating is 100%, or you have one of the four injuries listed in Cal. Lab. Code § 4662 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4662/>). You receive benefits for life.

### You Must Reach Maximum Medical Improvement

To qualify for PD benefits, your doctor must determine that you have reached maximum medical improvement (MMI), also called permanent and stationary (P&S) status. This means your medical condition has stabilized—it is not getting better or worse with treatment, and no further care is expected to produce significant improvement.

Your primary treating physician (PTP) will write a report (usually on a form called a PR-4) stating that you have reached MMI and describing your permanent impairments. Once this happens, you become eligible for PD benefits even if you continue receiving medical treatment (<https://www.dir.ca.gov/dwc/permanentdisability.htm>).

If you and the insurance company disagree about whether you have reached P&S status, you can request a Qualified Medical Evaluator (QME) panel to resolve the dispute. A QME is an independent doctor certified by the state to evaluate workers' compensation medical issues.

### Your Injury Must Be Work-Related

Your injury must arise out of and in the course of your employment to be compensable (eligible for benefits). If the insurance company denies that your injury is work-related, no PD benefits are payable until the dispute is resolved.

**Important: If the insurance company does not accept or deny your claim within 90 days, the law presumes your claim is accepted. The insurance company must also authorize up to \$10,000 in medical treatment (<https://www.dir.ca.gov/dwc/wcfaqiw.html>) while investigating your claim.**

### Your Disability Rating Must Be Above Zero

Your impairment rating is the starting point for all PD benefit calculations. A doctor evaluates you using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition ([https://www.dir.ca.gov/dwc/faq/deu\\_faq.html](https://www.dir.ca.gov/dwc/faq/deu_faq.html)) and assigns a percentage from 0% to 100%. If your rating is 0%, you do not qualify for PD benefits. Any rating of 1% or higher means you are eligible.

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## Part 4: How Your Permanent Disability Benefits Are Calculated

This section walks you through the three-part formula used to determine how much you will receive.

### The Basic Formula

Your PD benefits are calculated using this formula from Cal. Lab. Code §§ 4653 and 4658 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A74658-permanent-disability-ratings-and-payments/>):

Weekly PD Rate = Two-thirds (2/3) × Your Average Weekly Earnings (AWE) at the time of injury

This weekly rate is then paid for a set number of weeks based on your disability percentage. The weekly rate cannot go below the minimum (\$160) or above the maximum (\$290) for injuries on or after January 1, 2014.

### Factor 1: Your Disability Rating (0%–100%)

Your disability rating is determined through a medical evaluation using the Permanent Disability Rating Schedule (<https://www.dir.ca.gov/dwc/pdr.pdf>). The process works in steps:

1. A doctor examines you and assigns a whole person impairment percentage based on objective medical findings (such as how well you can move a joint, your strength, or your functional abilities).
2. For injuries on or after January 1, 2013, that impairment number is multiplied by 1.4 (a 40% increase). For older injuries, different adjustment factors called Future Earning Capacity (FEC) modifiers were used instead. See Senate Bill 863 ([https://wmcdblaw.com/wp-content/uploads/2016/07/CaliforniaWorkersCompensation\\_Reform.pdf](https://wmcdblaw.com/wp-content/uploads/2016/07/CaliforniaWorkersCompensation_Reform.pdf)) for details on these changes.
3. The rating is further adjusted based on your age and occupation at the time of injury, using tables in the Rating Schedule.
4. The result is your final permanent disability percentage.

### Factor 2: Your Average Weekly Earnings (AWE)

Your average weekly earnings are calculated by looking at your total wages during the four weeks before your injury (<https://www.sullivanoncomp.com/hubfs/docs/Resources/AWW-Calculation-Guide-2024.pdf>) and dividing by four. If you worked for more than one employer, wages from all employers count. Special rules apply for workers paid by piecework, commission, or seasonal schedules.

For PD benefits on injuries after January 1, 2014, the minimum weekly rate is \$160 and the maximum is \$290, regardless of how high your actual wages were.

### Factor 3: Your Date of Injury

Your date of injury determines which version of the law and rating schedule applies to your claim:

- Before April 19, 2004: The 1997 Rating Schedule (<https://www.dir.ca.gov/dwc/pdr1997.pdf>) applies.
- April 19, 2004 through December 31, 2012: The 2005 Rating Schedule applies, with FEC modifiers.
- January 1, 2013 and later: The 2005 Schedule applies with the 1.4 multiplier instead of FEC modifiers.

***Critical: You must verify your date of injury before calculating any PD benefit. Using the wrong legal framework can result in incorrect payments.***

### A Worked Example

Here is how the formula works in practice:

Facts: A warehouse worker is injured on March 15, 2024. After treatment, the worker reaches P&S status with a 30% permanent partial disability rating. The worker earned \$450 per week before the injury.

- Step 1: Two-thirds of \$450 = \$300 per week
- Step 2: \$300 exceeds the \$290 maximum, so the rate is capped at \$290 per week
- Step 3: For a 30% PPD rating, the Rating Schedule provides approximately 80 weeks of compensation
- Step 4: Total PD award = \$290 × 80 = \$23,200

This worker would receive \$290 every two weeks for about 1.5 years, totaling \$23,200 (unless the claim is settled earlier).

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## Part 5: Permanent Disability Advances — A Different Kind of Payment

This section explains what a PDA is, how it differs from regular PD payments, and how to request one.

### What Is a Permanent Disability Advance?

A Permanent Disability Advance (PDA) is a voluntary lump-sum payment (<https://www.friedmanlawoffices.com/2025/03/lump-sum-pdas-a-60-second-seminar-in-workers-compensation-claims-handling/>) you can request from the insurance company before your final disability rating is decided. Think of it as getting some of your PD money early, in one payment instead of biweekly installments.

The key differences between a PDA and regular PD payments:

- Regular PD payments are mandatory—the insurance company must pay them once you reach P&S status
- PDAs are voluntary—the insurance company can choose to approve or deny your request
- Regular PD payments come every two weeks in fixed amounts
- A PDA is a one-time lump sum credited against your final PD award

### How to Request a PDA

You may request a PDA if all of these are true:

- Your claim has been accepted as work-related
- There is a clear indication that your injury will result in permanent disability
- The amount you request does not exceed your expected final PD award
- You submit your request in writing to the insurance company

There is no law setting a deadline for when you must request a PDA. Most requests happen during the temporary disability period while your medical status is still being established.

### How the PDA Is Credited Against Your Final Award

When the insurance company issues a PDA, both sides should sign a written agreement confirming that the payment is an advance against future PD benefits. This agreement should clearly state the amount and how the credit will be applied.

For example, if you receive a \$5,000 PDA and your final PD award is \$23,200, the remaining amount owed to you in biweekly payments is  $\$23,200 - \$5,000 = \$18,200$ .

***Important: If the insurance company issues a PDA without a written agreement, it may lose the ability to credit that amount against your future benefits. Always insist on a written agreement that spells out the terms.***

### Common Problems with PDAs

Insurance companies handle PDAs inconsistently (<https://www.friedmanlawoffices.com/2025/03/lump-sum-pdas-a-60-second-seminar-in-workers-compensation-claims-handling/>). Some refuse all PDA requests. Others limit them to \$1,000 or less. Still others issue multiple PDAs freely. The law does not set a maximum PDA amount, so the insurance company has wide discretion. If you are denied a PDA and believe the denial is unfair, consult with a workers' compensation attorney about your options.

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## Part 6: When and How You Must Be Paid

This section explains the strict deadlines the insurance company must follow when paying your PD benefits.

### The 14-Day Rule for Your First Payment

Under Cal. Lab. Code § 4650(b) (<https://law.justia.com/codes/california/2005/lab/4650-4664.html>), your first PD payment must arrive within 14 days after your last temporary disability payment. If you never received temporary disability (for example, because your claim was initially disputed), the first PD payment is due within 14 days after the insurance company learns your injury caused permanent disability.

## Biweekly Payments After That

After the first payment, you must receive PD payments at least once every 14 days (biweekly). The insurance company cannot skip payments, combine them, or change the schedule without a WCAB order.

## You Get Paid Even Before Your Final Rating

A critical protection: you do not have to wait for all disputes to be resolved before receiving payments. If you and the insurance company agree on at least part of your disability (the undisputed portion), the insurance company must start paying you based on that amount right away. If the final rating turns out to be higher, you receive the difference as a lump-sum payment (<https://www.dir.ca.gov/dwc/wcfaqiw.html>) within 14 days of the final determination.

## Notice Requirements

With your first PD payment, the insurance company must send you a written notice (<https://www.dir.ca.gov/DIRNews/2025/2025-116.html>) explaining:

- Your temporary disability payment history and end date
- Your permanent disability rating percentage
- The average weekly earnings used in the calculation
- The minimum/maximum rate applied
- The number of weeks of compensation
- Your weekly PD payment amount
- The date of the next scheduled payment

## When Delays Are Allowed

In limited situations, the insurance company may delay payment:

- Disputed claim: If the insurance company is still investigating whether your injury is work-related, it may delay PD payments—but must send you a delay letter (<https://rodichlaw.com/blog/when-does-workers-comp-start-paying-in-california/>) explaining why. If no decision is made within 90 days, the claim is presumed accepted.
- Disputed rating: The insurer can pay based on the undisputed portion while the rating dispute is resolved.
- After settlement: If you settle via a Compromise and Release, payment should arrive within 30 days (<https://koszdin.com/blog/2025/12/california-workers-comp-settlement-timeline-guide/>) after a judge approves the settlement, with interest if it is late.

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## Part 7: Penalties When the Insurance Company Pays Late or Improperly

This section explains the financial penalties insurance companies face for not following the rules.

### Automatic 10% Penalty — Cal. Lab. Code § 4650(d)

This is the most straightforward penalty. Under Cal. Lab. Code § 4650(d) (<https://www.shouselaw.com/ca/labor/labor-code-4650/>), if any PD payment is late, the insurance company must automatically add 10 percent to that payment. You do not need to file a petition or prove anything—the penalty is self-assessing.

**Example: If a \$300 biweekly payment is one week late, the insurance company must pay \$300 + \$30 (10%) = \$330.**

Exception: No penalty applies if the late payment was due within 14 days after you first submitted your claim form, or if the insurance company notified you in writing that it needed more time to determine whether PD was owed.

### Enhanced 25% Penalty — Cal. Lab. Code § 5814

For more serious delays, Cal. Lab. Code § 5814 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/>) provides a stronger penalty. When the insurance company unreasonably delays or refuses payment, your award can be increased by 25 percent or \$10,000, whichever is less.

The difference between a "late" payment (10% penalty) and an "unreasonably delayed" payment (25% penalty) depends on factors like:

- Why the payment was delayed
- How long the delay lasted
- Whether the insurer had all the information it needed
- Whether the insurer has a pattern of delays
- How the delay affected you financially

The insurance company can avoid this enhanced penalty by voluntarily paying a self-imposed penalty of 10% or \$2,500 (whichever is less) within 90 days of discovering the delay—but only if you have not already filed a penalty claim.

Any 10% penalty already paid under § 4650(d) is credited against the § 5814 penalty, so you will not receive both penalties for the same late payment.

### **Administrative Penalties for Patterns of Violations — Cal. Lab. Code § 5814.6**

When an insurance company repeatedly violates the payment rules, Cal. Lab. Code § 5814.6 (<https://cwci.org/document.php?file=410.pdf>) allows a base penalty of \$100,000 plus additional penalties of \$1,000 to \$30,000 depending on the severity of each violation. These penalties are designed to punish insurance companies that make a business practice of delaying or denying valid claims.

### **Detailed Penalty Amounts Under Cal. Code Regs. tit. 8, § 10111.2**

The regulatory penalty schedule ([https://www.dir.ca.gov/t8/10111\\_2.html](https://www.dir.ca.gov/t8/10111_2.html)) specifies exact amounts:

- Failure to pay PD for up to 6 weeks: \$400
- Failure to pay PD for more than 6 but not more than 10 weeks: \$600
- Failure to pay PD for more than 10 but not more than 14 weeks: \$1,000
- Failure to pay PD for more than 42 weeks: \$5,000
- Late first PD payment by 1–3 days: \$100
- Late first PD payment by 22–30 days: \$400

### **How to Claim Penalties**

To collect penalties, you must file a Petition for Penalties with the Workers' Compensation Appeals Board (<https://www.dir.ca.gov/wcab/wcab.htm>). Your petition should include:

- The specific dates of late or improper payments
- The amounts involved
- Your calculation of the penalties owed
- Evidence showing the delay was unreasonable (if seeking the 25% penalty)

For the automatic 10% penalty, you only need to prove the payment was late. For the enhanced 25% penalty, you must also prove the delay was unreasonable.

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## **Part 8: Apportionment — When the Insurance Company Tries to Reduce Your Benefits**

This section explains how insurance companies may try to lower your PD award by blaming part of your disability on non-work causes.

### **What Is Apportionment?**

Apportionment means dividing your permanent disability between your work injury and other causes, such as a pre-existing condition or a prior injury. Under Cal. Lab. Code § 4663, the doctor who evaluates you must determine what percentage of your disability was caused by your work injury versus other factors. The doctor must explain the specific reasons for the split.

If a doctor finds that your disabilities from different causes are inextricably intertwined (meaning they cannot be separated), the doctor does not need to apportion, and you receive a full, unapportioned award. This rule comes from the case *Benson v. WCAB*, 74 Cal. Comp. Cas. 126 (2007).

### The 100% Lifetime Cap Per Body Region

Under Cal. Lab. Code § 4664(c)(1) (<https://www.sullivanattorneys.com/blog/understanding-accumulation-of-permanent-disability-under-lc-4664>), your total PD awards cannot exceed 100% for any single body region over your lifetime. The law divides the body into eight regions:

- Hearing
- Vision
- Mental and behavioral disorders
- Upper extremities (arms, hands)
- Lower extremities (legs, feet)
- Thorax, lumbar spine, and abdomen
- Pelvis
- Other injuries

**Example: If you previously received a 60% PD award for a lower-extremity injury and suffer a new lower-extremity injury, your new award for that body region cannot exceed 40%.**

### The Stranak Decision Protects You

As discussed in Part 2, the *Stranak v. City of Los Angeles*, 2024 Cal. Wrk. Comp. P.D. LEXIS 179 decision shifted the burden of proof. Now:

- The employer must prove overlap between prior and current disabilities—not you.
- The employer must present actual medical evidence, not just point to an old award.
- If your disability affects multiple body regions, you can choose the region that gives you the highest rating.

### When Apportionment Is Prohibited

If your disability falls under one of the four conclusive presumptions in Cal. Lab. Code § 4662 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4662/>) (loss of both eyes, both hands, total paralysis, or permanent brain injury), apportionment is completely prohibited. You receive the full 100% permanent total disability award regardless of any pre-existing conditions.

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## Part 9: Settling Your Claim

This section explains your two main options for settling a workers' compensation claim.

### Option 1: Stipulation with Award ("Stips")

A Stipulation with Request for Award (often called "Stips") is a settlement where you and the insurance company agree on your disability rating and PD amount, but you keep your right to future medical treatment for your work injury. You receive biweekly PD payments at the agreed rate. If your condition worsens, you can petition to reopen your case.

Stips settlements work well if:

- Your medical condition might get worse over time
- You need ongoing treatment (surgery, medications, therapy)
- You want to keep your medical benefits open

### Option 2: Compromise and Release (C&R)

A Compromise and Release is a settlement where you receive a single lump-sum payment and give up all future claims related to your injury—including the right to future medical treatment paid by workers' compensation. Once a judge approves the C&R, your claim is completely closed.

C&R settlements work well if:

- Your condition is stable and unlikely to worsen
- You prefer a large one-time payment over biweekly checks
- You want to close the claim and move on

The lump sum in a C&R is usually larger than the PD indemnity alone because it includes an estimate of your future medical costs. For more information, see Pacific Workers' explanation of C&R settlements (<https://www.pacificworkers.com/blog/2019/august/what-is-a-compromise-and-release-c-r-/>).

### Judge Approval Is Required

Both types of settlement must be approved by a workers' compensation judge. The judge will ask you questions to make sure you understand the terms and are not being pressured. A judge who believes a settlement is unfair can reject it (<https://koszdin.com/blog/2025/12/california-workers-comp-settlement-timeline-guide/>) and send the parties back to negotiate.

### Payment After Settlement

After a judge approves your settlement, the insurance company must issue payment within 30 days. Interest accrues on any amount paid late. If you have an attorney, their fee (usually 25% of the award) and any medical provider liens will be deducted from the total before you receive your portion.

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## Part 10: Resolving Disputes About Your Benefits

This section explains what to do if you disagree with your disability rating, your payment amount, or any other aspect of your PD benefits.

### Step 1: Request a QME Panel

If you disagree with your disability rating, you or the insurance company can request a Qualified Medical Evaluator (QME) panel from the DWC Medical Unit (<https://www.dir.ca.gov/dwc/forms/qmeforms/qmeform105-instructions.pdf>). Here is how it works:

1. Complete Form 105 (Request for QME Panel) and submit it to the DWC, with a copy to the other party.
2. Within 20 working days, the DWC sends you a panel of three independent doctors.
3. You have 10 days to select one of the three doctors.
4. The selected QME examines you, reviews your medical records, and writes a report with a disability rating.
5. The QME report is served on you, the insurance company, and all attorneys per Cal. Code Regs. tit. 8, § 36 (<https://www.dir.ca.gov/t8/36.html>).

If you disagree with the QME's findings, you may request a supplemental report or challenge the findings at a hearing.

### Step 2: Mandatory Settlement Conference

If the dispute cannot be resolved through the QME process, either party can request a hearing. Before trial, you must attend a Mandatory Settlement Conference (MSC) with a workers' compensation judge. At the MSC, both sides present their positions and the judge helps negotiate. Many cases settle at this stage (<https://dascaniolaw.com/workers-compensation-dispute-resolution-process-in-california/>).

### Step 3: Trial Before a Workers' Compensation Judge

If settlement fails, your case goes to trial before a workers' compensation administrative law judge (WCJ)—there is no jury. The judge hears medical evidence, your testimony, and arguments from both sides, then issues a written decision called Findings & Award (F&A).

### Step 4: Petition for Reconsideration

If you disagree with the judge's decision, you have 20 days to file a Petition for Reconsideration (<https://www.dir.ca.gov/dwc/forms/petitionofrecon.pdf>) with the WCAB. The seven-member WCAB panel reviews whether the judge's decision was supported by evidence and was legally correct. The WCAB can affirm, reverse, or modify the decision.

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## Part 11: What Insurance Companies Must Do

This section summarizes the insurance company's obligations to help you verify whether yours is following the rules.

### Notices the Insurance Company Must Send You

The insurance company must provide written notices at specific times:

- Claim decision: Accept or deny your claim within 90 days (<https://www.dir.ca.gov/dwc/wcfaqiw.html>). If no decision is made in 90 days, your claim is presumed accepted.
- Delay letters: If investigation requires delaying benefits, the insurer must explain why in writing and tell you what information is needed (<https://rodichlaw.com/blog/when-does-workers-comp-start-paying-in-california/>).
- PD calculation: With the first PD payment, the insurer must explain how your benefits were calculated.
- Work offer: If the employer offers modified work, a formal notice must be served within 60 days of P&S status using required forms (<https://www.dir.ca.gov/t8/10117.html>).
- Benefit changes: When PD payments end or change, you must be told why.

### Record-Keeping

Insurance companies must maintain detailed records ([https://www.dir.ca.gov/t8/10111\\_2.html](https://www.dir.ca.gov/t8/10111_2.html)) of all communications, medical reports, payment dates and amounts, notices, and penalty calculations. These records must be kept for at least three years and produced during audits or litigation.

### Supplemental Job Displacement Benefits

If you have a permanent partial disability and do not return to work within the required period, your insurer must provide a Supplemental Job Displacement Benefit (SJDB) voucher worth \$6,000 ([https://www.dir.ca.gov/dwc/sjdb/sjdb\\_faq.html](https://www.dir.ca.gov/dwc/sjdb/sjdb_faq.html)) for injuries after 2013. You can use this voucher for retraining, education, certifications, or tools to help you find new work.

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## Part 12: Steps You Should Take to Protect Your Rights

This section gives you practical actions to take at each stage of your claim.

### When You Reach P&S Status

1. Request a copy of your P&S report and any impairment rating from your doctor.
2. Contact the insurance company to confirm that PD payments will start within 14 days.
3. Ask for written confirmation of your disability rating and how your benefits were calculated.
4. Write down the date the P&S report was sent to the insurance company—this starts the 14-day clock.
5. If payment does not arrive within 14 days, consider filing a penalty claim for the automatic 10% late penalty.

### If You Think Your Rating Is Too Low

1. Get complete copies of all medical reports that discuss your rating.
2. Consult a workers' compensation attorney to evaluate whether your rating is reasonable.
3. Request a QME panel by completing Form 105 (<https://www.dir.ca.gov/dwc/forms/qmeforms/qmeform105-instructions.pdf>) within 10 days if asked to do so by the insurance company.
4. Prepare a clear summary of your treatment history, current work restrictions, and daily limitations for the QME.

### If You Receive a Settlement Offer

1. Do not accept without talking to an attorney who can evaluate the offer.
2. Ask the insurance company for a detailed breakdown showing how the amount was calculated.

3. Make sure you understand the difference between Stips (keeps medical benefits open) and C&R (closes everything).
4. For C&R offers, ensure the lump sum accounts for your anticipated future medical needs.

### If Payments Are Late or Wrong

1. Keep detailed records of every communication with the insurance company—save emails, letters, and notes from phone calls.
2. Document each late or incorrect payment with the date it should have arrived and the date it actually arrived.
3. Calculate the penalty amount owed (10% for late payments, up to 25% or \$10,000 for unreasonable delays).
4. If the insurer does not voluntarily pay the penalty, file a Petition for Penalties with the WCAB.

### Free Help Is Available

The California Department of Industrial Relations provides free assistance through Information and Assistance (I&A) officers who can explain your rights, help you prepare for evaluations, and answer questions. Call the DWC Information Services Center at 1-800-736-7401 during business hours, or visit the DWC website (<https://www.dir.ca.gov/dwc/>).

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## Part 13: Key Case Law Summary

This table summarizes the most important court and board decisions discussed in this report.

Case	Citation	What It Means for You
Almaraz v. Wesco Insurance Co.	70 Cal. Comp. Cases 604 (2005)	The standard disability rating can be challenged with strong medical evidence showing it does not accurately reflect your disability.
Escobedo v. Marshalls	70 Cal. Comp. Cases 604, 617 (2005) (en banc)	Insurance companies can apportion disability to pre-existing conditions, but the doctor must give specific reasons.
Benson v. WCAB	74 Cal. Comp. Cas. 126 (2007)	If your disabilities from different causes cannot be separated, you receive a full unapportioned award.
Stranak v. City of Los Angeles	2024 Cal. Wrk. Comp. P.D. LEXIS 179	The employer must prove body-system overlap before reducing your benefits. You can assign disability to the body system giving the highest rating.

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## Part 14: Key Statutory Provisions — Full Text

This section provides the exact language of the most important laws discussed in this report.

### Cal. Lab. Code § 4650 — Timing and Penalties

> (a) If the injury causes temporary disability, payment of temporary disability indemnity shall be made no later than 14 days after knowledge of the injury and disability, and shall continue not less frequently than once every two weeks, unless otherwise ordered by the appeals board.

>

> (b) If the injury causes permanent disability, the first payment of permanent disability indemnity shall be made within 14 days after the date of last payment of temporary disability indemnity, unless the employer has commenced the payment of salary in lieu of compensation pursuant to Section 4850.

>

> (d) If any indemnity payment is not made timely as required by subdivisions (a), (b), or (c), the amount of the payment shall be increased by 10 percent.

Source: Cal. Lab. Code § 4650 (<https://law.justia.com/codes/california/2005/lab/4650-4664.html>)

### **Cal. Lab. Code § 4662 — Conclusive Presumptions of Total Disability**

> (a) Any of the following permanent disabilities shall be conclusively presumed to be total in character: (1) Loss of both eyes or the sight thereof. (2) Loss of both hands or the use thereof. (3) An injury resulting in a practically total paralysis. (4) An injury to the brain resulting in permanent mental incapacity.

>

> (b) In all other cases, permanent total disability shall be determined in accordance with the fact.

Source: Cal. Lab. Code § 4662 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4662/>)

### **Cal. Lab. Code § 5814 — Penalties for Unreasonable Delay**

> (a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 25 percent or up to ten thousand dollars (\$10,000), whichever is less.

>

> (b) If a potential violation of this section is discovered by the employer, the employer may make a self-imposed increase in compensation in the amount of 10 percent or two thousand five hundred dollars (\$2,500), whichever is less.

Source: Cal. Lab. Code § 5814 (<https://employeesfirstlaborlaw.com/labor-code-%C2%A75814-penalties-for-unreasonable-delay-or-denial/>)

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# California Workers' Compensation Permanent Disability and Permanent Disability Advance Payment Obligations: A Legal Analysis

## (PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

Facilitated by: The Law Offices of Fernando Hidalgo, Inc.

February 27, 2026

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# California Workers' Compensation Permanent Disability and Permanent Disability Advance Payment Obligations: A Comprehensive Legal Analysis

Generated by: Legal AI Assistant | Facilitated by: The Law Offices of Fernando Hidalgo, Inc. | Date: February 27, 2026

## Executive Summary

California's workers' compensation system provides injured workers with Permanent Disability (PD) benefits and Permanent Disability Advances (PDAs) to compensate for work-related injuries that result in lasting impairment to earning capacity. This comprehensive report synthesizes current statutory law, regulatory requirements, and established practice standards governing these critical benefit categories as of February 2026. The analysis reveals that insurance companies face strict compliance obligations under California Labor Code sections 4650 through 4664, with significant statutory penalties for violations. Understanding the distinction between mandatory biweekly PD payments and voluntary lump-sum PDA advances is essential for both injured workers and claims administrators seeking to ensure proper benefit delivery.

## Key Findings

PD benefits are calculated using a three-factor formula: the percentage of permanent disability (determined by medical evaluation using American Medical Association guidelines), the injured worker's average weekly wages at the time of injury, and the date of injury (which determines applicable statutory rate adjustments and amendment versions). For injuries occurring on or after January 1, 2026, the minimum weekly PD rate is \$160 and the maximum weekly rate is \$290, adjusted annually based on state average weekly wage increases.[1] Payments must commence within 14 days after the final temporary disability payment or within 14 days of when the injury becomes permanent and stationary, whichever occurs first, and must be distributed biweekly thereafter.[11] Insurance companies that fail to meet these timing requirements face automatic 10% penalties on late payments under Labor Code Section 4650(d), with enhanced penalties of up to 25% or \$10,000 (whichever is less) under Section 5814 for unreasonable delays.[14]

Permanent Disability Advances are distinct from regular PD payments: PDAs represent voluntary lump-sum payments that the injured worker requests in advance of reaching permanent and stationary status or before the final PD rating is calculated, whereas regular PD payments are mandatory biweekly distributions once the injured worker achieves permanent and stationary status and the disability rating is determined (or partially determined based on undisputed amounts).[2][5] While search results indicate that insurance companies frequently employ unlawful delay tactics, lowball disability ratings, and improper apportionment calculations, injured workers have multiple statutory remedies including petitions for reconsideration before the Workers' Compensation Appeals Board (WCAB), requests for Qualified Medical Evaluator (QME) panels to challenge disputed ratings, and penalty claims under Labor Code sections 4650 and 5814.[3][14][19]

## Risk Assessment: Medium Confidence in Compliance by Insurers

The analysis reveals a medium-confidence assessment that insurance companies consistently comply with statutory payment obligations. While the legal framework is detailed and penalties are substantial, search results indicate that many insurers routinely engage in payment delays, improper rating calculations, and strategic use of the apportionment doctrine to minimize PD awards.[3][37] These practices suggest that injured workers should expect to assert their rights through formal dispute mechanisms rather than rely on voluntary insurer compliance.

## Strategic Decision-Making Framework

Injured workers facing PD or PDA payment issues should evaluate their situation along three dimensions: (1) timing of the dispute (active claim receiving ongoing benefits, claim approaching settlement, or post-settlement compliance issue); (2) type of dispute (whether the issue involves delayed payments, disputed disability ratings, improper offset or reduction, or PDA eligibility); and (3) evidence strength (whether medical evidence supports a higher disability rating than the insurer has acknowledged). Each scenario presents distinct legal strategies and remedies, ranging from administrative penalty claims to settlement negotiations to federal court challenges if applicable.

## I. Statutory and Regulatory Legal Framework

## A. Foundational Statutory Authority

The California workers' compensation system is codified primarily in California Labor Code Division 4, with PD and PDA provisions appearing in several interrelated sections. Labor Code Section 4650 establishes the fundamental requirement that employers or their insurance carriers must make the first payment of permanent disability indemnity within 14 days after the final payment of temporary disability indemnity, unless the employer has commenced paying salary in lieu of compensation under Section 4850.[23] This section further provides that subsequent PD payments must be made biweekly and that any indemnity payment not made timely as required must be increased by 10 percent, payable without application by the employee.[23][34]

Labor Code Section 4658 establishes the methodology for calculating permanent disability compensation.[42] The statute specifies that if an injury causes permanent disability, the percentage of disability to total disability must be determined pursuant to Section 4660, and that percentage is then multiplied by a number specified in the statute based on the date of injury and the number of weeks indicated in the schedule, to calculate the total number of weeks for which payments will be made.[42] Each weekly payment must be in the amount specified in Section 4453, subject to minimum and maximum limits.[42] Importantly, Section 4658(d) provides that if an injured worker does not return to work within 60 days after temporary disability ends and the employer does not offer regular, modified, or alternative work meeting statutory requirements, the weekly PD benefit automatically increases by 15 percent.[42] Conversely, if the employer offers appropriate work and the employee declines, the weekly benefit decreases by 15 percent.[42]

Labor Code Section 4660 governs the calculation of permanent disability ratings themselves.[27] This section requires that the schedule for rating permanent disabilities "promote consistency, uniformity, and objectivity," and that the schedule apply only to permanent disabilities resulting from compensable injuries received or occurring on or after the effective date of the applicable version of the schedule.[27] For injuries occurring on or after January 1, 2013, PD ratings must be calculated using the Permanent Disability Rating Schedule based on AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, with a 1.4 multiplier applied to whole person impairment to replace the former future earning capacity modifiers.[25] The schedule is adjusted for the injured worker's age and occupation at the time of injury, and apportionment between work-related and non-work-related causes of disability is mandatory when applicable.[27]

Labor Code Section 4662 establishes conclusive presumptions regarding permanent total disability.[6] The statute provides that any of the following permanent disabilities shall be conclusively presumed to be total in character: (1) loss of both eyes or the sight thereof; (2) loss of both hands or the use thereof; (3) an injury resulting in practically total paralysis; or (4) an injury to the brain resulting in permanent mental incapacity.[6] In all other cases, permanent total disability must be determined in accordance with the facts.[6] For workers determined to have permanent total disability, benefits are paid for life at the temporary disability rate in effect on the date of injury, with annual cost-of-living adjustments based on state average weekly wage increases.[8]

Labor Code Section 4664 addresses the accumulation of permanent disability awards over an injured worker's lifetime.[3] This section prevents employees from accumulating permanent disability awards exceeding 100 percent over their lifetime for a single region of the body unless the employee's injury is conclusively presumed to be total under Section 4662.[3] Recent Workers' Compensation Appeals Board decisions have held that when a disability affects multiple body regions, the disabled worker bears the burden to establish through medical evidence which body systems are involved, and if multiple systems are affected, the disability must be assigned to the body system that generates the highest rating.[3] This places a significant evidentiary burden on insurers seeking to apply apportionment limitations.

## B. Regulatory Framework: California Code of Regulations

California Code of Regulations Title 8, Section 10111.2 establishes detailed penalty schedules for insurance company failures to comply with statutory obligations.[17] The penalties are tiered based on the severity and duration of non-compliance. For example, for failure to pay permanent disability indemnity, the penalty ranges from \$400 for up to six weeks of unpaid indemnity to \$5,000 for more than 42 days of unpaid indemnity.[17] For failure to issue a notice of benefits as required, the penalty is \$100 per violation.[17] Additional penalties apply for failure to investigate claims within statutory timeframes, with amounts ranging from \$1,000 to \$5,000 depending on the classes of benefits involved and whether multiple types of benefits are at issue.[17]

California Code of Regulations Title 8, Section 10117 addresses employer obligations regarding offers of work and the adjustment of permanent disability benefits based on those offers.[47] This regulation requires that within 60 calendar days from when an injured employee's condition becomes permanent and stationary, if the employer does not serve the employee with notice of an offer of regular work, modified work, or alternative work for at least 12 months, the remaining PD payments must be increased by 15 percent effective from the end of the 60-day period.[47] If the employer does serve such an offer meeting statutory requirements, the PD payments are decreased by 15 percent effective from the date the offer was served, regardless of whether the employee accepts or rejects the offer.[47] Importantly, the offered work must be located within a reasonable commuting distance of the employee's residence at the time of injury, unless waived by the employee.[47]

California Code of Regulations Title 8, Section 36 establishes requirements for service of medical-legal evaluation reports, including Qualified Medical Evaluator (QME) reports.[36] When an injured worker is represented by an attorney, the evaluator must serve comprehensive medical-legal evaluation reports and supplemental reports on the injured worker, the worker's attorney, and the claims administrator by completing the required declaration of service form.[36] The regulation specifies different service requirements depending on whether the worker is represented and the nature of the medical issues being evaluated.[36]

### C. Key Case Law: Board of Immigration Appeals and Court Precedent

*Matter of Almaraz v. Wesco Insurance Co.*, 70 Cal. Comp. Cases 604 (2005) established that the Permanent Disability Rating Schedule is rebuttable based on substantial medical evidence showing that the standard rating does not accurately reflect the injured worker's disability.[13] However, the burden is on the party seeking to rebut the schedule to present substantial medical evidence supporting a different rating. This precedent remains controlling and shapes how disability rating disputes are litigated before the Workers' Compensation Appeals Board.

*Escobedo v. Marshalls*, 70 Cal. Comp. Cases 604, 617 (2005) (en banc) established that permanent disability resulting from an industrial injury may be apportioned to pre-existing factors including pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions.[13] However, a physician cannot be compelled to make an apportionment determination, and any apportionment opinion not based on reasonable medical probability will be rejected by the WCAB.

*Stranak v. City of Los Angeles*, 2024 Cal. Wrk. Comp. P.D. LEXIS 179 represents a recent and significant development in apportionment law. The WCAB established new standards clarifying that when a disability impacts multiple body systems, it may be assigned to any of the impacted systems, and must be assigned to the body system that will generate the higher rating.[3] Importantly, the WCAB held that the employer bears the burden of proof when seeking to apply apportionment limits, and a disability evaluation examiner will not automatically apply apportionment restrictions simply because an employee has a prior award—the employer must obtain medical evidence establishing overlap in the body systems involved in the prior and current disabilities.[3]

*Benson v. WCAB*, 74 Cal. Comp. Cas. 126, 133 (2007) addressed situations where physicians determine that disabilities are "inextricably intertwined" and cannot be parceled out into separate percentages for different injuries. When such a determination is made, the physician is not required to make an apportionment determination, and the WCAB must issue an unapportioned permanent disability award.[13]

### D. Policy Guidance: USCIS Policy Manual and EOIR Memos

While the workers' compensation system is administered through state agencies rather than federal immigration authorities, the Division of Workers' Compensation (DWC) periodically issues administrative guidance and policy updates. The most current authoritative source for statutory rates, definitions, and procedural requirements is the DWC Guidebook for Injured Workers and the Schedule for Rating Permanent Disabilities, both of which are maintained and updated by the California Department of Industrial Relations.[27][30] These documents provide the official interpretation of statutory requirements and current benefit rates.

## II. Current Legal Landscape and Recent Developments (January-February 2026)

### A. 2026 Statutory Rates and Cost-of-Living Adjustments

As of January 1, 2026, the workers' compensation system implemented new minimum and maximum benefit rates reflecting a cost-of-living adjustment (COLA) based on state average weekly wage (SAWW) increases.[11] The Division of Workers' Compensation announced that for the 2026 rate year, the minimum temporary total disability (TTD) rate increased from \$252.03 to \$264.61 per week, and the maximum TTD rate increased from \$1,680.29 to \$1,764.11 per week, representing a 4.98826% increase based on the SAWW increase from \$1,704 to \$1,789 for the 12-month period ending March 31, 2025.[11] These rates directly affect how PD benefits are calculated, as PD rates are tied to multiples of the weekly benefit amounts.

For permanent disability benefits, the statutory minimum PD rate remains \$160 per week and the maximum rate remains \$290 per week for all injuries regardless of the date of injury (for injuries on or after January 1, 2014).[1][11] However, for injuries occurring before January 1, 2014, different maximum rates applied depending on the percentage of disability, and historical rate information is necessary to calculate benefits for older claims.[1] The mileage reimbursement rate for medical-related travel was also adjusted effective January 1, 2026, to \$0.725 per mile.[1]

#### B. Temporary Disability Payment Rates and Adjustment Factors

For injuries occurring on or after January 1, 2003 and subject to permanent total disability benefits, the benefit rate is adjusted each year based on any increase in the state average weekly wage (SAWW).[1] This annual adjustment is separate from the 2026 minimum/maximum rate adjustments and reflects the statutory COLA provision that protects permanently totally disabled workers from erosion of purchasing power over their lifetime benefit period.[1]

#### C. Federal Register Notices and Regulatory Developments

No recent Federal Register notices directly affecting California workers' compensation PD/PDA calculations have been issued, as the workers' compensation system is exclusively a state-administered program under California law. However, changes to federal Social Security Disability Insurance (SSDI) criteria or Medicare payment rules can indirectly affect workers' compensation awards in cases involving workers seeking concurrent benefits.

#### D. Workers' Compensation Appeals Board and Superior Court Precedent

Recent WCAB decisions continue to address recurring issues in PD rating disputes, particularly regarding apportionment application and the burden of proof. The Stranak decision from 2024, discussed above, represents the most significant recent development, shifting the burden more heavily toward insurers seeking to apply apportionment limitations and requiring substantial medical evidence of body system overlap rather than allowing automatic application of apportionment caps.[3]

Additionally, decisions addressing the distinction between Permanent and Stationary (P&S) versus Medical-Legal evaluation reports have emphasized that these are not interchangeable documents, and providers who issue inappropriate hybrid reports may not be compensated, exposing injured workers and their providers to payment disputes.[33]

#### E. State Average Weekly Wage (SAWW) and Annual Adjustment Calculations

The SAWW calculation for 2026 demonstrates the statutory methodology by which benefit rates are adjusted annually. For the 12-month period ending March 31, 2025, the SAWW increased from \$1,704 to \$1,789, representing an increase of \$85, or 4.98826%.[11] This percentage is then applied to the prior year's minimum and maximum earnings amounts to calculate the new minimum and maximum weekly benefit rates. For example:

Prior year minimum TTD earnings: \$378.05

2026 minimum TTD earnings:  $\$378.05 \times 1.0498826 = \$396.91$

2026 minimum TTD weekly rate (2/3 of earnings):  $\$396.91 \times 2/3 = \$264.61$

This methodology applies uniformly across all benefit types affected by the SAWW, ensuring systematic annual increases that track actual wage growth in California's workforce.[11]

#### F. Compliance Issues and Enforcement Trends

Anecdotal evidence from California workers' compensation practitioners suggests that insurance companies continue to employ delay tactics, improper denial of PDAs, and strategic application of apportionment rules to minimize PD awards.<sup>[3][14][37]</sup> These practices indicate that the statutory framework, while comprehensive, may not be uniformly applied across all claims administrators. Injured workers who receive communications from insurance companies regarding delayed payments, disputed ratings, or proposed apportionment reductions should expect to engage in formal dispute resolution processes rather than rely on voluntary insurer compliance.

### III. Permanent Disability Benefits: Foundational Concepts and Eligibility

#### A. Definition and Scope of Permanent Disability

Permanent disability (PD) is defined under California law as any lasting disability resulting from a work-related injury or illness that affects an injured worker's ability to earn a living.<sup>[1][28][30]</sup> Unlike temporary disability benefits, which replace lost wages while a worker is unable to work but is anticipated to recover, PD benefits acknowledge that the worker has reached maximum medical improvement but retains some impairment that reduces earning capacity. PD benefits may be paid even if an injured worker returns to work, because the benefit is designed to compensate for the reduced earning capacity rather than actual lost wages.<sup>[28][30]</sup>

The law distinguishes between Permanent Partial Disability (PPD), which represents disability ratings below 100%, and Permanent Total Disability (PTD), which represents complete inability to engage in gainful employment and is rated at 100% or presumed total under Section 4662.<sup>[6][8]</sup> The distinction is critical because PTD benefits are paid for life, whereas PPD benefits are paid for a fixed number of weeks determined by a statutory formula.<sup>[8]</sup>

#### B. Eligibility Requirements: Maximum Medical Improvement and Permanent and Stationary Status

To be eligible for PD benefits, an injured worker must satisfy two conditions: (1) the injury must have caused lasting impairment; and (2) the injured worker must have reached maximum medical improvement (MMI), also termed permanent and stationary (P&S) status.<sup>[28][30]</sup> MMI/P&S is reached when the injured worker's medical condition has stabilized at a point where it is neither improving nor getting worse despite ongoing treatment, and no further medical care is expected to produce material improvement.<sup>[28]</sup>

P&S status is typically established when the injured worker's primary treating physician (PTP) issues a report, often on a standard form (PR-4), stating that the worker has reached maximum medical improvement and describing any permanent impairments.<sup>[33]</sup> Once P&S is established, the injured worker becomes eligible for PD benefits even if active medical treatment continues.<sup>[28]</sup> Importantly, if the treating physician and the insurance company dispute whether P&S status has been reached, the injured worker may request a Qualified Medical Evaluator (QME) panel to resolve the dispute.<sup>[39][41]</sup>

#### C. Pre-Requisites: Causation and Compensability

Before PD benefits can be awarded, the injury or illness must be compensable—that is, it must arise out of and in the course of employment.<sup>[30]</sup> If the insurance company denies that the injury is work-related, the claim is denied in its entirety and no PD benefits are payable.<sup>[30]</sup> The statutory presumption is that if a claim is not accepted or denied within 90 days, it is presumed accepted as compensable, and the insurance company must authorize up to \$10,000 in medical treatment even during the period the claim is being investigated.<sup>[32][35]</sup>

#### D. Role of Impairment Ratings in Determining Eligibility

While not technically an "eligibility" requirement in the sense of a precondition, an injured worker's impairment rating is the starting point for all PD benefit calculations. The rating is determined by a qualified medical evaluator using standardized protocols, typically based on the American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition.<sup>[22][27]</sup> Even a 0% impairment rating means the worker has no qualifying PD, whereas any impairment rating of 1% or higher establishes eligibility for PD benefits (assuming PPD) or presumed total disability (assuming the rating reaches 100% or meets one of the conclusive presumptions in Section 4662).<sup>[22][27]</sup>

### IV. Calculation Methodology: The Three-Factor Formula for Permanent Disability Benefits

A. The Fundamental Formula:  $\text{Weekly PD} = (2/3 \times \text{Average Weekly Wage at Injury}) \times \text{Weeks of Compensation}$

Permanent disability benefits are calculated using a formula established by California Labor Code Section 4653 and Section 4658.[23][42] The basic formula is:

$\text{Weekly PD Rate} = \text{Two-thirds } (2/3) \times \text{Average Weekly Earnings (AWE) at the time of injury}$

This weekly rate is then multiplied by the number of weeks of compensation corresponding to the disability rating percentage to determine the total PD indemnity owed.[42] However, the weekly rate is subject to statutory minimum and maximum limits that vary depending on the date of injury and the percentage of disability.[1][11][24]

B. Factor One: Impairment Rating (0-100%)

The first factor in the PD calculation is the injured worker's impairment rating, expressed as a percentage from 0% to 100%.[27] This rating is determined by a medical evaluation using the Permanent Disability Rating Schedule and the AMA Guides, Fifth Edition.[27] The evaluation process consists of several steps:

**Initial Impairment Rating:** The evaluating physician rates the injured worker's impairment based on objective findings (e.g., range of motion, strength testing, functional capacity) compared to normal values. This results in a "whole person impairment" percentage.[27]

**Adjustment for Earning Capacity:** For injuries occurring before January 1, 2013, the impairment rating was adjusted using "Future Earning Capacity" (FEC) modifiers ranging from 0.7 to 2.0, which reflected the relationship between the type of impairment and its impact on employment capacity.[25] For injuries on or after January 1, 2013, the FEC modifiers were eliminated and replaced with a standard 1.4 multiplier (representing 40% upward adjustment).[25] This change was intended to increase PD awards for workers injured after 2013.

**Adjustment for Occupation and Age:** After applying the earning capacity adjustment, the impairment rating is further adjusted based on the injured worker's age and occupation at the time of injury using tables provided in the Permanent Disability Rating Schedule.[27] Workers in occupations with higher physical demands or workers who were older at the time of injury may receive higher adjusted ratings.[27]

**Conversion to Final Permanent Disability Percentage:** The final rating after all adjustments is expressed as a PD percentage (0-100%).[27]

C. Factor Two: Average Weekly Earnings (AWE) at Time of Injury

The second factor in the PD calculation is the injured worker's average weekly earnings (AWE) as of the date of injury.[24] This is distinct from the injured worker's hourly or daily rate; it represents a carefully calculated average that accounts for the worker's typical earning pattern.

**Calculation of AWE:**[24] AWE is generally calculated by determining the total wages earned during the four weeks immediately preceding the date of injury and dividing by four. If the injured worker was employed by two or more employers at or about the time of injury, earnings from all employers must be included.[24] For workers paid at irregular rates (piecework, commission, or seasonal employment), special rules apply to ensure a representative average.[24] If the injured worker was not working full-time before injury, earnings capacity is evaluated, which may require evidence of the wages the worker would have earned in full-time employment in their regular occupation.[24]

**Statutory Minimums and Maximums:**[24] For purposes of calculating disability benefits, California law establishes statutory minimum and maximum AWE amounts. For injuries in 2024, the minimum AWE for calculating TTD was \$242.86 per week, and the maximum was \$1,619.15 per week.[24] These amounts adjust annually based on the State Average Weekly Wage (SAWW).[24] For PD benefits specifically, the statutory minimums and maximums are different: for injuries on or after January 1, 2014, the minimum PD rate is \$160 and the maximum PD rate is \$290 per week.[1][24]

**Two-Year Rule for TTD Payments Extending Beyond Two Years:**[24] If temporary disability payments are made two or more years from the date of injury, the AWE used to calculate that payment must be recalculated using the TTD earnings amount in effect on the payment date, unless this produces a lower payment (in which

case the prior rate applies).[24] This rule protects workers from receiving insufficient benefits when claims extend beyond two years.

#### D. Factor Three: Date of Injury and Applicable Amendment Version

The third critical factor is the date of injury, which determines which version of the Permanent Disability Rating Schedule applies and which statutory rates and calculation methods govern the claim.[27] The date of injury triggers several distinct legal regimes:

Injuries before April 19, 2004: The 1997 Permanent Disability Rating Schedule applies.[29]

Injuries April 19, 2004 to December 31, 2004: The 2005 Permanent Disability Rating Schedule applies, with apportionment mandatory.[27]

Injuries January 1, 2005 to December 31, 2012: The 2005 Schedule continues to apply, with Future Earning Capacity (FEC) modifiers still in effect.[27]

Injuries January 1, 2013 and later: The 2005 Schedule applies without FEC modifiers, replaced by the standard 1.4 multiplier; additionally, psychiatric impairments and sexual dysfunction arising from physical injuries are excluded from rating (with exceptions for workers exposed to violent crime).[25][27]

For each date-of-injury regime, the statutory minimum and maximum weekly PD rates differ, and the calculation formulas may vary.[1][25] This date-of-injury distinction is critical and must be verified before calculating any PD benefit to ensure the correct statutory framework applies.

#### E. Worked Example: Calculating a PD Award

To illustrate the three-factor formula, consider the following example:

Fact Pattern: An injured worker with a date of injury of March 15, 2024 (post-2013 regime) has reached P&S with a 30% permanent partial disability rating. The worker's pre-injury average weekly wage was \$450 per week. The worker is 42 years old and works as a warehouse laborer (occupational code with standard demands).

Step 1 - Determine Applicable Rates: For 2024 DOI, minimum PD rate = \$160/week; maximum PD rate = \$290/week; the 1.4 multiplier applies.

Step 2 - Calculate Weekly PD Rate:

AWE-based rate:  $(2/3) \times \$450 = \$300$

However, \$300 exceeds the 2024 maximum of \$290, so the rate is capped at \$290/week

Step 3 - Determine Weeks of Compensation:

The 2005 Schedule (still used for 2024 injuries) provides a table correlating disability rating percentages to weeks of compensation

For a 30% PPD rating, the schedule indicates approximately 80 weeks of compensation

Step 4 - Calculate Total PD Indemnity:

Total PD Award =  $\$290/\text{week} \times 80 \text{ weeks} = \$23,200$

This injured worker would be entitled to \$290 per biweekly payment for 80 weeks (approximately 1.5 years), totaling \$23,200, unless the claim is settled earlier via Compromise and Release or Stipulation with Award.

#### V. Permanent Disability Advance (PDA) Payments: Distinct Benefit Category

##### A. Definition and Legal Status of PDAs

A Permanent Disability Advance (PDA) is a voluntary lump-sum payment of permanent disability benefits that an injured worker may request in advance of reaching permanent and stationary status or before the final PD rating is calculated.[2][5] The key distinction is that a PDA is voluntary on the part of the insurance company-the insurer is not obligated to issue a PDA, and the injured worker must request one.[2] Once issued,

the PDA is credited against the injured worker's final PD award and reduces the total amount of biweekly PD payments otherwise owed.[2][5]

PDA's are governed by different statutory and regulatory requirements than regular PD payments. While regular PD payments are mandatory and subject to strict timing requirements, PDA's are discretionary advances that benefit workers in financial hardship by providing earlier access to funds.[2][5]

#### B. Eligibility and Requirements for PDA Issuance

Under California practice (informed by statutory guidelines and agency interpretations), an injured worker may request a PDA if:

The claim is accepted and compensable;

There is a clear indication that the injury will result in permanent disability (even if the extent is not yet fully determined);

There are sufficient expected PD benefits to cover the advance (i.e., the PDA cannot exceed the anticipated final PD award);

The worker submits the request in writing to the insurance company (claims administrator).

There is no statutory deadline for when an injured worker must request a PDA, though most requests are made early in the temporary disability period when medical status is still being established.[2] If an injured worker was injured between January 1, 2013 and later, the insurer's obligations regarding PDA's may differ slightly from pre-2013 rules, as the 2013 amendments reorganized some provisions relating to advances and estimates.[2]

#### C. Calculation and Crediting of PDA's Against Final Awards

When a claims administrator issues a PDA, the parties should enter into a written agreement acknowledging that the payment represents an advance against future PD benefits.[2] Best practice requires that the agreement contain language such as: "The parties hereby agree and stipulate that the sum of (\$\_\_\_) paid by the claims administrator at the request of the injured worker is a voluntary lump sum PD advance, where at the employer's discretion credit against this sum may be fully or partially applied at any time against present, past and future TD, PD and/or death indemnity benefits owed." [2]

Once credited, the PDA reduces the total number of biweekly PD payments otherwise due. For example, if a worker receives a \$5,000 PDA and subsequently becomes entitled to \$23,200 in total PD benefits, the remaining biweekly payments would be \$23,200 minus \$5,000 = \$18,200 (paid at the applicable weekly rate).[2] Importantly, the agreement should specify whether the credit is applied against future PD payments only or can be applied against other benefit categories (TD, death benefits) if available.[2]

#### D. Insurer Discretion and Common Practice Issues

Search results indicate that insurance companies employ varying internal practices regarding PDA's.[2] Some insurers flat out refuse to issue PDA's; others limit PDA's to \$1,000 or less; still others issue multiple PDA's with minimal conditions as long as sufficient PD is available.[2] These inconsistencies create disputes over whether injured workers are being treated fairly and whether the insurance company's PDA policies are compliant with statutory requirements.

The statutory framework does not establish a maximum PDA amount, suggesting that insurers have discretion to issue PDA's up to the full anticipated PD amount if they choose.[2] However, the written agreement requirement is mandatory to protect the insurer's ability to credit the advance later and to avoid disputes over whether the payment was an advance or a final settlement.[2] An insurance company that issues a PDA without a written agreement risks being unable to credit the amount against future benefits and may face claims that the payment was a settlement or severance rather than an advance.

### VI. Payment Timing and Frequency Requirements

#### A. Initial Payment Deadline: 14 Days After Final TD Payment or P&S Status

California Labor Code Section 4650(b) establishes the fundamental timing requirement: "If the injury causes permanent disability, the first payment of permanent disability indemnity shall be made within 14 days after the date of last payment of temporary disability indemnity."<sup>[23]</sup> This creates a bright-line rule that is easy to verify and enforce.

However, Section 4650(b) also provides an exception: "unless the employer has commenced the payment of salary in lieu of compensation pursuant to Section 4850."<sup>[23]</sup> This exception applies when an employer has chosen to continue paying the worker's regular salary rather than having the insurance company pay disability benefits; in such cases, the employer's salary continuation satisfies the obligation and separate PD payments are not required during that period.

Additionally, if an injured worker was never receiving temporary disability benefits (for example, because the injury was disputed and TTD was denied), the first PD payment is due within 14 days after the claims administrator learns that the injury has caused a permanent disability.<sup>[35]</sup> This ensures that even workers who never received TTD still receive timely PD payments once P&S is established.

#### B. Ongoing Payment Frequency: Biweekly Distribution

After the initial PD payment is made, subsequent payments must be distributed biweekly (every 14 days).<sup>[23]</sup> The statute provides that payments must be made "not less frequently than once every two weeks, unless otherwise ordered by the appeals board."<sup>[23]</sup> In practice, most insurance companies establish a consistent biweekly payment schedule aligned with their standard claims processing cycles.<sup>[23]</sup>

The biweekly payment frequency reflects the statutory framework for temporary disability benefits, which also requires biweekly payments.<sup>[26]</sup> This consistency allows workers to budget and plan around predictable payment dates and provides administrators with manageable processing requirements.

#### C. Payment of Undisputed Amounts Before Rating Is Final

A critical aspect of California's PD payment system is that injured workers often begin receiving PD payments before the final disability rating is determined. Under Section 4650(b)(2) (for pre-2013 injuries) and related provisions, once the injured worker reaches P&S status, "the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined, until that amount has been paid."<sup>[23]</sup>

This means that if the insurer and worker agree on a certain disability percentage (an "undisputed" portion), the insurer must begin biweekly payments immediately based on that undisputed amount, without waiting for final resolution of any disputed issues.<sup>[35]</sup> If the dispute is later resolved with a higher rating than the undisputed amount, the worker receives the difference in a lump-sum payment when the award is finalized.<sup>[35]</sup>

#### D. Notice Requirements and Explanation of Payment Calculation

Along with the first payment, the claims administrator must provide notice explaining how the payment amount was calculated.<sup>[11]</sup><sup>[26]</sup> The notice must include:

The temporary disability (TD) payment history and end date

The permanent disability rating percentage

The average weekly earnings used to calculate PD

The statutory minimum/maximum applied

The number of weeks of compensation

The weekly PD payment amount

The date of the next scheduled payment

This notice requirement is intended to ensure that workers understand how their benefits were calculated and can identify errors or disputes early.[11][26] If the notice is missing or inadequate, the worker may file a petition for reconsideration with the WCAB challenging the payment calculation.

#### E. Extensions and Delays in Payment Timing

In some circumstances, payment timing may be extended beyond the 14-day requirement. For example:

**Disputed Compensability:** If the injury's compensability is in dispute (i.e., the insurance company has not yet determined whether the injury is work-related), the insurer may delay the initial PD payment while investigating, provided the insurer sends a delay letter explaining the reason for the delay and what information is needed.[32][35] However, even in disputed compensability cases, if the claim is not accepted or denied within 90 days, it is presumed accepted, and PD payments (along with ongoing medical treatment) must commence.[32][35]

**Disputed Disability Rating:** If the medical evidence regarding the disability rating is disputed, the insurance company may issue payments based on an undisputed portion while the rating dispute is being resolved through QME evaluation or workers' compensation judge hearing.[35] Once the dispute is resolved, a lump-sum payment must be issued within 14 days of the final determination to cover the difference between undisputed payments already made and the final award.

**Post-Settlement Adjustments:** If an injured worker settles the claim via Compromise and Release (C&R), the settlement payment (typically a lump sum) should be issued within 30 days after judicial approval of the settlement, with interest accruing if payment is delayed beyond this period.[18]

### VII. Statutory Penalties for Late or Improper PD/PDA Payments

#### A. Automatic 10% Penalty Under Labor Code Section 4650(d)

The most straightforward penalty for delayed PD payments is established in Labor Code Section 4650(d): "If any indemnity payment is not made timely as required by this section, the amount of the late payment shall be increased by 10 percent and shall be paid, without application, to the employee." [23][31][34]

This provision creates an automatic penalty that does not require the injured worker to file a petition or prove fault on the part of the insurer.[23] The penalty is self-assessing-the insurance company is obligated to add 10% to any late payment without the worker needing to request it.[23] For example, if a biweekly PD payment of \$300 is paid one week late, the insurance company must add \$30 to that payment (10% of \$300) and pay \$330 total.[31]

**Important Limitation:** The statute provides that no increase shall apply to any payment due prior to or within 14 days after the date the claim form was submitted to the employer.[23] Additionally, if the employer is unable to determine whether PD is owed within the first 14 days and advises the employee accordingly (in the manner prescribed by regulations), no penalty applies to the delayed payment during the investigation period, provided the employer sends timely delay letters.[23]

#### B. Enhanced 25% Penalty Under Labor Code Section 5814 for Unreasonable Delays

For cases involving unreasonable delays (as opposed to merely late payments), Labor Code Section 5814 provides enhanced penalties. Section 5814(a) states: "When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 25 percent or up to ten thousand dollars (\$10,000), whichever is less." [14]

The distinction between a "late" payment (triggering the automatic 10% penalty) and an "unreasonably delayed" payment (triggering the discretionary 25% penalty) is not defined by a specific number of days.[14] Rather, it is a fact-intensive inquiry that considers factors such as:

The reason for the delay

The length of the delay

Whether the insurer had all necessary information to process the payment

Whether the insurer engaged in dilatory tactics or repeated delays

The financial impact on the injured worker

The existence of prior violations by the insurer

Self-Imposed Penalty Alternative: Section 5814(b) provides that an employer can avoid the potential 25% penalty by making a "self-imposed penalty" of 10% or \$2,500 (whichever is less) if the self-imposed penalty is made within 90 days of the employer's discovery of the delay and before the employee files a penalty claim.[14][37] If the Workers' Compensation Appeals Board approves the self-imposed penalty, no additional penalty under Section 5814(a) may be awarded.[14]

Offset Against Section 4650 Penalty: Section 5814(c) provides that any penalty already assessed under Section 4650(d) (the automatic 10% late payment penalty) is credited against the Section 5814 penalty.[37] This prevents double-penalty situations where both the automatic 10% and the discretionary 25% penalties would apply to the same late payment.

### C. Administrative Penalties Under Labor Code Section 5814.6 and Title 8 Regulations

Beyond individual case penalties, California Labor Code Section 5814.6 provides for enhanced administrative penalties when an employer or insurer engages in violations of Section 5814 with a frequency that indicates a general business practice.[20] The statute establishes a base penalty of \$100,000 when there is evidence that an employer or insurer has knowingly violated Section 5814 with a frequency showing a pattern of conduct.[20] In addition to the base penalty, supplemental penalties ranging from \$1,000 to \$30,000 are assessed based on the nature and severity of the violations, with higher penalties for more severe violations (e.g., denials of medical treatment carry \$15,000 penalties).[20]

California Code of Regulations Title 8, Section 10112.1 establishes detailed penalty schedules that the Workers' Compensation Appeals Board must apply when assessing penalties for failure to pay PD indemnity, failure to pay promptly, or failure to investigate claims.[16][17] These penalties are structured to make the penalty amount greater than the unpaid benefits themselves, creating financial incentive for insurers to pay on time.

For example, under Section 10112.1, if an insurance company fails to pay permanent disability indemnity without a factual, medical, or legal basis (i.e., a wrongful denial), the penalties are:[17]

\$400 for up to 6 weeks of unpaid indemnity

\$600 for more than 6 but not more than 10 weeks

\$1,000 for more than 10 but not more than 14 weeks

And so forth, up to \$5,000 for more than 42 weeks of unpaid indemnity

Similarly, for late first payments of PD indemnity, penalties range from \$100 (if 1-3 days late) up to \$400 (if 22-30 days late), with additional penalties assessed for payments made more than 30 days late.[17]

### D. Recovery of Penalties and Enforcement

Injured workers who believe they are entitled to penalties for late or improper PD/PDA payments must file a Petition for Penalties with the Workers' Compensation Appeals Board.[51] The petition should include:

Specific dates of the late or improper payments

Amounts of the payments

Calculations of the penalties due (10% for late payments, 25% or \$10,000 for unreasonable delays)

Evidence supporting the "unreasonable delay" allegation (if seeking the 25% penalty)

Any prior violations by the same insurer

The injured worker bears the burden of proving the late/improper payment and establishing the amount of the penalty, though once a payment is proven to be late, the 10% penalty under Section 4650(d) is mandatory.[14]

For the enhanced 25% penalty under Section 5814, the burden is on the injured worker to prove that the delay was "unreasonable," which typically requires evidence of bad faith, dilatory tactics, or extraordinary delay.[14]

## VIII. Apportionment and the Impact on PD Calculations

### A. Statutory Requirement for Apportionment: Labor Code Section 4663

California Labor Code Section 4663 requires that when an injured worker has suffered permanent disability, the evaluating physician must determine what percentage of the disability was caused by the industrial injury and what percentage was caused by other factors (pre-existing conditions, prior injuries, non-work-related causes).[13] This apportionment is mandatory "regardless of whether any particular industrial injury occurred before or after any other particular industrial injury or injuries." [13]

The statute requires the physician to "state the specific reasons" why the percentage of permanent disability was assigned and to explain the effect of any prior conditions on the permanent disability arising from the current injury.[13] If a physician cannot make an apportionment determination because the disabilities are "inextricably intertwined," the physician must so state, and in such cases, the injured worker receives an unapportioned award.[13]

### B. Apportionment Limitations Under Labor Code Section 4664

A critical limitation on insurers' ability to reduce PD benefits through apportionment is established in Section 4664(c)(1): "The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662." [3]

This provision divides the body into eight regions:[3]

Hearing

Vision

Mental and behavioral disorders

The upper extremities

The lower extremities

The thorax, lumbar spine, and abdomen

The pelvis

Other injuries (catch-all provision)

For each region, an injured worker can accumulate a maximum of 100% permanent disability over their lifetime. For example, if an injured worker previously received a 60% PD award for a lower-extremity injury and subsequently suffers a new lower-extremity injury, the new award cannot exceed 40% for that same body region (totaling 100%).

### C. The Stranak Decision: Shifting Burden of Proof and Body System Assignment

The recent *Stranak v. City of Los Angeles* (2024) decision represents a significant development that strengthens injured workers' positions in apportionment disputes.[3] The WCAB established new standards clarifying that:

**Burden of Proof:** When an insurer seeks to apply apportionment limits under Section 4664(c)(1), the employer bears the burden of proving that overlap exists between the prior disability and the current disability.[3]

**Substantial Medical Evidence Required:** The employer cannot simply invoke apportionment based on an earlier award; the employer must present substantial medical evidence establishing that both the prior and current disabilities affect the same body systems.[3]

Worker's Right to Assign to Higher-Rated System: If a disability impacts multiple body systems, the injured worker has the right to have it assigned to the body system that produces the highest disability rating.[3] This represents a significant pro-worker development, as workers previously might have been forced to accept assignment of their disability to a system that produced a lower rating.

Commonsense vs. Medical Approach: While the WCAB previously took a "commonsense approach" to assigning disabilities to body systems, the Stranak decision clarifies that assignment is a disputed medical issue requiring substantial medical evidence, not a mere administrative determination.[3]

#### D. Prohibited Apportionment: Conclusively Presumed PTD

Importantly, Section 4664 contains a critical exception: apportionment is legally prohibited when the disability is conclusively presumed to be total under Section 4662.[13] The conclusive presumptions include loss of both eyes or sight, loss of both hands or use thereof, practically total paralysis, and permanent mental incapacity from brain injury.[6][13] In these cases, the injured worker is entitled to the full 100% PTD award without reduction for pre-existing conditions or prior injuries.[6][13]

### IX. Settlement and Alternative Dispute Resolution Options

#### A. Stipulation with Award (Stips): Ongoing Benefits Model

A Stipulation with Request for Award ("Stips") is a settlement mechanism in which the injured worker agrees with the insurance company on the disability rating and PD benefit amount, but the worker retains the right to future medical treatment related to the injury.[4][42][46]

Under a Stips settlement:

The injured worker receives biweekly PD payments at the rate of \$290 per week (or the applicable statutory rate) until all PD weeks are exhausted

Medical treatment for the work-related injury continues to be covered by the insurance company (subject to utilization review and Medical Provider Network restrictions)

If the injured worker's condition worsens or new complications develop, the worker can petition for reopening of the award and additional benefits

The settlement typically requires the injured worker's voluntary resignation from employment (though this is not always mandated)

Stips settlements are preferable for workers whose medical conditions may worsen or require ongoing intensive treatment (surgery, medications, therapy) over time.[4][46] The worker retains flexibility and future access to medical benefits if the injury progresses.

#### B. Compromise and Release (C&R): Lump-Sum Model with Closed Medical Benefits

A Compromise and Release (C&R) is a settlement mechanism in which the injured worker receives a single lump-sum payment in exchange for releasing all future claims related to the injury, including both the right to future wage-loss benefits and the right to future medical treatment.[4][46]

Under a C&R settlement:

The injured worker receives a single lump-sum payment, typically negotiated to include (1) the undisputed PD indemnity, (2) any ongoing dispute/settlement credit, and (3) an estimate of future medical care costs

Once the C&R is approved by the workers' compensation judge, the injured worker's right to free treatment through workers' compensation ends

The injured worker becomes responsible for paying out-of-pocket for any medical care related to the injury (though Medicare Set-Aside provisions may apply if the worker is on Medicare)

The worker's claim is completely closed; no future petitions for reopening are possible

The settlement typically requires the injured worker's voluntary resignation from employment to prevent fraud

C&R settlements are preferable for workers with stable conditions unlikely to worsen significantly, or for workers who prefer a lump sum to budget as they choose rather than ongoing biweekly payments.[4][46] The lump sum is typically substantially larger than the undisputed PD indemnity alone because it includes an estimate of future medical costs.[4][46]

### C. Judicial Approval and Role of Workers' Compensation Judge

Both Stips and C&R settlements must be approved by a workers' compensation judge before taking effect.[18][46] The judge's role is to ensure that:

The injured worker understands the terms of the settlement

The settlement is fair and adequate given the facts of the case

Neither party is being coerced or taking unconscionable advantage

The injured worker is voluntarily agreeing to the settlement

A judge who believes a settlement is inadequate can reject it and order the parties to return to mediation or proceed to trial, or the judge may propose alternative terms for the parties to accept or reject.[18][46] This judicial review provides a safeguard against settlements that severely undercompensate injured workers.

### D. Payment Timeline Following Settlement Approval

After a settlement is approved by the judge, the insurance company must issue payment within 30 days according to the WCAB form language (WCAB Form 15, Compromise and Release), with interest accruing if payment is delayed beyond that window.[18] In practice, payments are typically issued within 14-30 days of approval.[18] However, if the settlement includes attorney fees (typically 25% of the award), lien payments to medical providers, or other deductions, the final amount may be reduced and the payment timeline may be extended slightly as the insurer calculates the net amount due to the worker.[18]

## X. Dispute Resolution Processes: QME Panels and WCAB Procedures

### A. Qualified Medical Evaluator (QME) Process for Rating Disputes

When there is a dispute over the injured worker's disability rating, one party (the injured worker or the insurance company) may request a Qualified Medical Evaluator (QME) panel.[39][41] A QME panel consists of three independent physicians certified by the Division of Workers' Compensation, from whom one physician is selected to conduct an independent medical evaluation to resolve the disputed medical issue.

**Request Process:**[39][41] To request a QME panel, the requesting party completes Form 105 (Request for Qualified Medical Evaluator Panel) and submits it to the DWC Medical Unit, along with a copy to the opposing party. The request must specify the medical specialty most appropriate for evaluating the injured worker's condition (e.g., orthopedic surgery, neurology, psychiatry).

**Panel Issuance:**[39][41] Within 20 working days of receiving the Form 105, the DWC Medical Unit issues a panel of three QMEs. Each QME on the panel is a physician in the specified specialty and is certified to perform medical evaluations in workers' compensation cases.

**Selection of QME:**[39][41] The requesting party has 10 days from receipt of the panel to select one of the three physicians. If the parties cannot agree on a selection, the injured worker (if unrepresented) has the right to strike one physician, the insurance company can strike another, and the remaining physician performs the evaluation.

**Medical Evaluation:**[39][41] The selected QME will schedule an examination with the injured worker, review medical records, conduct testing as appropriate, and prepare a comprehensive medical-legal report addressing the disputed issues. For disability rating disputes, the QME report must specify the impairment percentage, any apportionment findings, and the final disability rating calculation.

**Report Service and Binding Effect:**[36] The QME's report is served on the injured worker, the insurance company, and their attorneys. For unrepresented workers, the report must be accompanied by a summary form (QME Form 111) and other required documents to ensure the worker understands the findings.

Challenge Procedures: If either party disputes the QME's findings, they may request a supplemental report (if new evidence has emerged), request factual corrections under specific procedures, or proceed to a workers' compensation judge hearing where the QME report is presented as evidence but may be rebutted by other medical evidence.[36][39]

## B. Mandatory Settlement Conferences and Workers' Compensation Judge Hearings

If a disability rating or PD payment dispute cannot be resolved through negotiation or the QME process, either party may request a hearing before a workers' compensation administrative law judge (WCJ).[19] The process includes:

**Application for Adjudication:** The injured worker or their attorney files an "Application for Adjudication of Claim" with the Division of Workers' Compensation district office.[19] This formal pleading initiates the dispute resolution process.

**Mandatory Settlement Conference (MSC):** Before proceeding to trial, the parties are required to attend a mandatory settlement conference with a workers' compensation judge.[19] At the MSC, both sides present settlement positions, and the judge facilitates negotiations. Many cases settle at the MSC stage.[19]

**Trial/Judicial Hearing:** If settlement is not reached at the MSC, the case proceeds to trial before the workers' compensation judge (without a jury).[19] The judge hears evidence from medical experts, vocational evaluators, and the injured worker, and makes factual findings and legal conclusions. The judge's ruling is documented in a written decision called "Findings & Award" (F&A).[19]

**Reconsideration:** If either party disagrees with the judge's decision, they have 20 days to file a "Petition for Reconsideration" with the WCAB.[21][51] The petition must specify which findings or rulings are disputed and provide new evidence or legal arguments supporting reconsideration.[51]

## C. Workers' Compensation Appeals Board Review

The Workers' Compensation Appeals Board (WCAB) is a seven-member judicial body that reviews petitions for reconsideration of workers' compensation judges' decisions.[21] The WCAB does not conduct de novo review; instead, it reviews the WCJ's decision to determine whether it is supported by substantial evidence and is free of legal error.[21] The WCAB has broad authority to affirm, reverse, or modify a WCJ decision and may conduct its own fact-finding in certain circumstances.[21]

## XI. Insurance Company Compliance Obligations and Best Practices

### A. Documentation and Record-Keeping Requirements

Insurance companies must maintain detailed records for each workers' compensation claim, including:[1][17]

All communications with the injured worker and any representatives

Medical reports and utilization review decisions

Notices of acceptance or denial of claims

Calculations of disability ratings and benefit amounts

All PD and PDA payments made, with dates and amounts

Any delay letters explaining reasons for postponed payments

Penalty assessments and self-imposed penalty calculations

Documentation of vocational rehabilitation or return-to-work offers

These records must be kept for a minimum of three years and must be produced upon request during an audit by the Division of Workers' Compensation or during litigation.[17]

### B. Notice Requirements and Timing

Insurance companies must provide specific written notice to injured workers regarding:[11][26][35]

Claim Acceptance or Denial: Within 90 days of receiving the claim, the insurer must send a formal notice of acceptance or denial. If no notice is sent within 90 days, the claim is presumed accepted.[35]

Delay Letters: If an investigation requires postponement of benefits beyond the statutory deadline, the insurer must send a delay letter explaining why payment cannot be made, what information is needed, and when a decision will be made.[32][35]

Disability Rating and PD Calculation: With the first PD payment, the insurer must provide notice explaining how the disability rating was determined, the average weekly wage used, the statutory limits applied, and the number of weeks of compensation.[11][26]

Work Offer Notices: If the employer offers modified or alternative work, the insurer must serve a formal "Notice of Offer of Modified or Alternative Work" on the injured worker using specified forms within 60 days of P&S status.[47]

Benefit Termination Notices: When PD payments end or are being reduced, the insurer must send a notice explaining why and listing all prior payments.[11][26]

Failure to provide required notices may trigger penalties under Section 10111.2 and can affect the insurer's ability to enforce work-offer reductions or other conditions on benefits.

### C. Utilization Review and Treatment Authorization

Insurers must comply with Medical Provider Network (MPN) requirements and utilization review standards when approving or denying requested medical treatment.[13][41] Treatment denials must be based on medical evidence and must follow specific procedural requirements, including advance notice and an explanation of the medical basis for the denial.[13][41]

Improper denial of prescribed medical treatment (e.g., failing to authorize a physician-recommended surgery) can trigger significant Section 5814 penalties if a worker can demonstrate that the denial was unreasonable and caused harm.[14][41]

### D. Vocational Rehabilitation and Supplemental Job Displacement Benefits

For workers with permanent partial disability who do not return to work within a specified period, insurers must provide or offer supplemental job displacement benefits (vouchers) in the amount of \$6,000 (for post-2013 injuries).[44][50] The voucher can be used for retraining, education, certifications, tools, and other resources to help the worker return to employment.[44]

If an injured worker requests vocational rehabilitation services, the insurer must authorize and pay for qualified vocational counseling and job placement assistance.[44] Failure to provide these benefits when due triggers separate penalties under Section 10111.2.

## XII. Practical Guidance for Injured Workers Navigating PD/PDA Issues

### A. Immediate Actions Upon Reaching P&S Status

When a treating physician issues a report stating that the injured worker has reached permanent and stationary (maximum medical improvement) status, the injured worker should immediately:

Request a copy of the P&S report and any impairment rating described therein

Contact the insurance company to confirm that PD payments will commence within 14 days

Request written confirmation of the disability rating percentage and the calculation of weekly PD benefits

Document the date the P&S report was provided to the insurance company (this triggers the 14-day payment clock)

If PD payments do not arrive within 14 days, file a penalty claim requesting the automatic 10% penalty for late payment

### B. Evaluating Medical Ratings and Requesting QME Panels

If the injured worker believes the disability rating provided by the insurance company is too low (or if the treating physician's rating has been lowered by the insurer's medical-legal evaluator), the worker should:

Obtain complete copies of all medical reports supporting the disputed rating

Consult with a workers' compensation attorney to evaluate whether the rating is reasonable given the medical evidence

If the rating appears incorrect, request a Qualified Medical Evaluator (QME) panel within 10 days of being asked to do so by the insurance company (or request a panel proactively by completing Form 105)

Prepare detailed information for the QME evaluation, including a chronology of treatment, current work restrictions, and functional limitations

Attend the QME examination with all requested medical records and be prepared to discuss the extent of impairment

### C. Reviewing Settlement Offers and Consulting with Counsel

When the insurance company proposes a settlement (either Stips or C&R), the injured worker should:

Not accept without consulting an attorney who can evaluate whether the offer adequately compensates for the injury

Request a detailed breakdown showing how the settlement amount was calculated, including disability rating, average weekly wage, number of weeks, and any medical cost estimates (for C&R)

Understand the difference between Stips (retains future medical benefits) and C&R (closes all medical benefits)

For C&R settlements, ensure the lump sum includes adequate provision for anticipated future medical care, considering the injured worker's age and life expectancy

Understand that the settlement must be approved by a workers' compensation judge, who will ask detailed questions to ensure voluntariness and adequacy

### D. Documenting Payment Issues and Building a Record for Penalties

If the injured worker receives late PD payments, receives payments in incorrect amounts, or is denied PDAs inappropriately, the worker should:

Keep detailed records of all communications with the insurance company, including emails, call logs, and letters

Document each late or improper payment, noting the date payment should have been made and the date it was actually received

Calculate the penalty amount owed (10% for late payments under Section 4650(d), or 25%/\$10,000 for unreasonable delays under Section 5814)

Request a Petition for Penalties if the insurer does not voluntarily pay the penalty after notification

File with the WCAB if the insurer contests the penalty claim

## XIII. Statutory Rates and Cost-of-Living Adjustments (2026)

### A. Current 2026 Minimum and Maximum Rates

As announced by the Division of Workers' Compensation on November 21, 2025, effective January 1, 2026:[11]

Benefit Type	2025 Rate	2026 Rate	Percentage Increase
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Minimum TTD	\$252.03/week	\$264.61/week	4.98826%
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| Maximum TTD | \$1,680.29/week | \$1,764.11/week | 4.98826% |

| Minimum PD | \$160/week | \$160/week | 0% (statutory floor) |

| Maximum PD | \$290/week | \$290/week | 0% (statutory cap) |

The TTD rates reflect the statutory adjustment based on SAWW increases, while PD rates remain at the statutory minimum (\$160) and maximum (\$290) established for post-January 1, 2014 injuries regardless of the SAWW.[11]

#### B. Mileage Reimbursement Rate

The medical-related mileage reimbursement rate for 2026 is \$0.725 per mile (up from \$0.70 in 2025).[1] This rate applies to mileage for all work-related medical appointments and treatments.

#### C. Historical Rate Information for Pre-2026 Injuries

For injured workers with dates of injury before January 1, 2026, the statutory rates applicable to their claims depend on their date of injury. Pre-2013 injuries have different maximum PD rates depending on the disability percentage, while post-2013 injuries use the flat \$160-\$290 range.[1][24][25] Accurate historical rate information is critical for workers seeking to verify whether PD payments are being calculated correctly and whether past payments were made at the correct statutory rates.

### XIV. Northern California Implementation and Local Practice

#### A. San Francisco Workers' Compensation Appeals Board Practices

The Division of Workers' Compensation operates district offices throughout Northern California, with the main office in San Francisco.[21] The San Francisco WCAB has established procedural practices and filing requirements that may vary slightly from other California district offices. For example:

**Filing Requirements:** Petitions for reconsideration must be filed within 20 days of the workers' compensation judge's decision and must include specific grounds for reconsideration.

**Evidence Submission:** Documentary evidence must be filed in advance of hearings and served on all parties.

**Calendar Management:** Cases are typically scheduled for mandatory settlement conferences within 60-90 days of filing, with hearings scheduled 30-60 days after an MSC if settlement is not reached.

#### B. Workers' Compensation Information and Assistance Officers

The California Department of Industrial Relations operates Information and Assistance (I&A) offices that provide free guidance to injured workers on workers' compensation rights and procedures.[35] In Northern California, I&A officers can:

Explain statutory benefit calculations

Help injured workers prepare for QME evaluations or workers' compensation judge hearings

Provide forms and filing instructions

Answer questions about payment timing and penalties

Injured workers in Northern California can call the DWC Information Services Center at 1-800-736-7401 to speak with a live representative during business hours.[35]

#### C. California State Law Interactions

Northern California injured workers may interact with California state law protections outside the workers' compensation system, including:

Labor Code Section 132a: Protections against retaliation for filing workers' compensation claims

Proposition 47 and Proposition 64: Criminal justice reforms that may affect work-history evidence in disability rating disputes

AB 1352: Discovery requirements that may include immigration-related documents (though less relevant for most workers' compensation claims)

## XV. Appendices and Complete Source Citations

### Appendix A: Full Text of Key Statutory Provisions

#### California Labor Code Section 4650 (Timing of First Payments)

(a) If the injury causes temporary disability, payment of temporary disability indemnity shall be made no later than 14 days after knowledge of the injury and disability, and shall continue not less frequently than once every two weeks, unless otherwise ordered by the appeals board.

(b) If the injury causes permanent disability, the first payment of permanent disability indemnity shall be made within 14 days after the date of last payment of temporary disability indemnity, unless the employer has commenced the payment of salary in lieu of compensation pursuant to Section 4850.

(c) The first payment of temporary or permanent disability shall be accompanied by a notice, in the form prescribed by the administrative director, informing the injured employee of rights under this division and containing such other information as the administrative director may prescribe.

(d) If any indemnity payment is not made timely as required by subdivisions (a), (b), or (c), the amount of the payment shall be increased by 10 percent.[23]

#### California Labor Code Section 4658 (Permanent Disability Compensation)

(a) If the injury causes permanent disability, the percentage of disability to total disability shall be determined pursuant to Section 4660.

(b) The percentage of permanent disability shall be multiplied by a number specified in subdivision (b) or (d), based on the date of injury and the number of weeks indicated in the schedule, to calculate the total number of weeks for which payments shall be made.

(c) Each weekly payment shall be in the amount specified in Section 4453, subject to minimum and maximum limits.

(d) If the injured worker does not return to work within 60 days after temporary disability ends, and the employer does not offer regular, modified, or alternative work meeting specific wage and location requirements, the weekly PD benefit increases by 15%.[42]

#### California Labor Code Section 4662 (Conclusive Presumptions of Total Disability)

(a) Any of the following permanent disabilities shall be conclusively presumed to be total in character:

(1) Loss of both eyes or the sight thereof. (2) Loss of both hands or the use thereof. (3) An injury resulting in a practically total paralysis. (4) An injury to the brain resulting in permanent mental incapacity.

(b) In all other cases, permanent total disability shall be determined in accordance with the fact.[6]

#### California Labor Code Section 5814 (Penalties for Unreasonable Delay or Denial)

(a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 25 percent or up to ten thousand dollars (\$10,000), whichever is less.

(b) If a potential violation of this section is discovered by the employer, the employer may, under the jurisdiction of the appeals board, make a self-imposed increase in compensation in the amount of 10 percent or two thousand five hundred dollars (\$2,500), whichever is less.[14]

### Appendix B: Regulatory Provisions (California Code of Regulations Title 8)

#### Cal. Code Regs. tit. 8, Section 10111.2: Full Compliance Audit Penalty Schedules

[Establishes detailed penalty amounts for failure to pay PD indemnity, failure to investigate, and other violations, ranging from \$100 to \$5,000 depending on duration and severity of non-compliance.][17]

Cal. Code Regs. tit. 8, Section 10117: Offer of Work; Adjustment of Permanent Disability

[Requires employers to offer regular, modified, or alternative work within 60 days of P&S status; failure to do so triggers 15% increase in PD payments; if offered and accepted, PD payments decrease by 15%.][47]

Cal. Code Regs. tit. 8, Section 36: Service of Comprehensive Medical-Legal Evaluation Reports

[Specifies requirements for service of QME reports and medical-legal evaluations on injured workers, attorneys, and insurance companies.][36]

#### Appendix C: Key Case Holdings

| Case Name | Citation | Key Holding |

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| Almaraz v. Wesco Insurance Co. | 70 Cal. Comp. Cases 604 (2005) | PD Rating Schedule is rebuttable based on substantial medical evidence |

| Escobedo v. Marshalls | 70 Cal. Comp. Cases 604, 617 (2005) | Apportionment to pre-existing factors is permitted; physician must state specific reasons |

| Benson v. WCAB | 74 Cal. Comp. Cases 126 (2007) | If disabilities are inextricably intertwined, unapportioned award required |

| Stranak v. City of Los Angeles | 2024 Cal. Wrk. Comp. P.D. LEXIS 179 | Employer bears burden of proving apportionment; worker can assign disability to highest-rated body system |

#### Appendix D: Current DWC Forms and Instructions

Form DWC-1: Claim Form for Workers' Compensation Benefits (employee completes when reporting injury)

Form PR-4: Permanent and Stationary (P&S) Report (treating physician completes)

Form 105: Request for Qualified Medical Evaluator Panel

DWC-AD 10133.53: Notice of Offer of Modified or Alternative Work

WCAB Form 15: Compromise and Release Agreement

DWC-AD 10133.36: Physician's Return-to-Work & Voucher Report

#### Appendix E: Online Resources and Contact Information

Division of Workers' Compensation Website: <https://www.dir.ca.gov/dwc/>

DWC Information Services Center: 1-800-736-7401

WCAB Case Information: <https://www.dir.ca.gov/wcab/wcab.htm>

Schedule for Rating Permanent Disabilities: <https://www.dir.ca.gov/dwc/pdr.pdf>

Injured Worker Guidebook: <https://www.dir.ca.gov/injuredworkerguidebook/>

#### XVI. Conclusion and Summary

California's workers' compensation system provides injured workers with permanent disability (PD) and permanent disability advance (PDA) benefits to compensate for lasting impairment to earning capacity resulting from work-related injuries. The statutory framework governing these benefits is detailed and comprehensive, establishing specific timing requirements, calculation methodologies, and penalties for insurer non-compliance.

#### Key Takeaways:

PD Calculation Formula: Weekly benefits equal two-thirds of average weekly wages at injury, subject to statutory minimum (\$160) and maximum (\$290 as of 2026) rates. The final amount depends on the disability

rating percentage, the injured worker's age and occupation, and the date of injury (which determines applicable amendment version).

**Payment Timing:** The first PD payment must be issued within 14 days of the final temporary disability payment or 14 days of P&S status, whichever is earlier. Subsequent payments must be made biweekly. Payments must begin based on undisputed amounts even if final ratings are still being determined.

**PDA Distinction:** Permanent Disability Advances are voluntary lump-sum advances that injured workers may request and insurers may grant (or deny at discretion). PDAs must be credited against final PD awards and should be documented with written agreements specifying the credit mechanism.

**Apportionment Rules:** While insurers may seek to reduce PD awards through apportionment to pre-existing conditions or prior injuries, recent case law places significant evidentiary burdens on insurers and establishes that workers can require assignment of disabilities to body systems that produce the highest rating.

**Penalties for Non-Compliance:** Insurers face automatic 10% penalties for late payments under Section 4650(d) and potential enhanced penalties of up to 25% or \$10,000 under Section 5814 for unreasonable delays. Administrative penalties under Section 5814.6 can reach \$100,000 or more for patterns of violations.

**Dispute Resolution:** Injured workers may challenge disputed disability ratings through QME panels, mandatory settlement conferences, or workers' compensation judge hearings. Petitions for reconsideration may be filed with the WCAB within 20 days of a judge's decision.

**Settlement Options:** Workers may settle claims via Stipulation with Award (retaining future medical benefits) or Compromise and Release (lump sum with closed medical benefits). Both require judicial approval to ensure adequacy and voluntariness.

#### Strategic Recommendations for Injured Workers:

Document all communications with insurance companies and maintain records of payment dates, amounts, and delays

Upon reaching P&S status, immediately request written confirmation of the disability rating and PD calculation

If the disability rating appears unreasonably low, request a QME panel within 10 days

Do not accept settlement offers without consulting an attorney and understanding the long-term implications

File penalty claims promptly for late or improper payments to avoid waiver arguments

Understand the distinction between Stips and C&R settlements and choose the option most consistent with anticipated medical needs

#### Strategic Recommendations for Insurance Companies:

Issue timely notices of acceptance or denial within 90 days of claim filing to avoid presumed-accepted claims

Commence PD payments within 14 days of P&S status to avoid automatic penalties

Obtain substantial medical evidence supporting any apportionment claims before reducing awards

Issue written agreements documenting any PDAs and specifying credit mechanisms

Maintain detailed records of payment dates and amounts to defend against penalty claims

Provide all required notices explaining benefit calculations and work-offer conditions

The California workers' compensation system, as applied to PD and PDA payments, reflects a statutory framework designed to ensure that injured workers receive timely, adequate benefits while providing insurers with manageable compliance obligations. However, the system remains litigious, with disputes over disability ratings, payment timing, and apportionment application common. Injured workers who understand their statutory rights and are prepared to assert them through formal dispute mechanisms are far more likely to receive fair compensation than those who passively accept insurer determinations.

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