

# Activities of Daily Living Assessment in California Workers' Compensation: Legal and Practice Analysis

## (PART-A INJURED WORKERS ANALYSIS)

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# ACTIVITIES OF DAILY LIVING ASSESSMENT IN CALIFORNIA WORKERS' COMPENSATION

This report explains how Activities of Daily Living (ADLs) are evaluated and used to calculate your permanent disability rating in California's workers' compensation system. ADLs are the everyday tasks you do — like walking, bathing, dressing, and eating — that a doctor measures to determine how much your work injury has permanently affected your life.

Your permanent disability rating directly determines how much money you receive for a work injury that causes lasting limitations. Understanding how ADLs work in this system helps you know what to expect during medical evaluations, what your doctor should be assessing, and how to protect your rights.

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## Part 1: The Legal Framework — Statutes and Regulations

This section covers the California laws and regulations that require doctors to use ADL assessment when rating your permanent disability.

### California Labor Code § 4660 — The Foundation

The main law governing permanent disability ratings is Cal. Lab. Code § 4660 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660/>). This law says that when determining your permanent disability percentage, three things must be considered:

- The nature of your physical injury or disfigurement
- Your occupation (the job you had when you were hurt)
- Your age at the time of injury

Whole Person Impairment (WPI) is a percentage that estimates how much your injury affects your overall ability to do daily activities. Under § 4660(b)(1), doctors must use the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, 5th Edition to determine your WPI. This is the medical guidebook that ties your injury to specific ADL limitations.

**Important: The AMA Guides define impairment based on how your injury affects your daily life activities — not your ability to work. Work capacity is handled separately through other parts of the rating calculation.**

### California Labor Code § 4660.1 — Injuries After January 1, 2013

If your injury happened on or after January 1, 2013, Cal. Lab. Code § 4660.1 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660-1/>) applies to your case. This law made important changes:

- Your WPI rating is multiplied by 1.4 (a 40 percent increase) to account for diminished future earning capacity (DFEC). This means the law recognizes that your actual wage loss is typically greater than the medical impairment number alone suggests.
- The rating schedule must promote consistency, uniformity, and objectivity across all cases.

**Critical: For injuries on or after January 1, 2013, § 4660.1(c) places limits on certain types of impairment. Sleep dysfunction, sexual dysfunction, and psychiatric disorder cannot increase your permanent disability rating when they arise from a physical injury — unless one of two exceptions applies:**

- You were a victim of a violent act or were directly exposed to a significant violent act, OR
- You suffered a catastrophic injury such as loss of a limb, paralysis, severe burn, or severe head injury

This means that even though sexual function and sleep are recognized ADLs in the AMA Guides, they cannot be rated as separate add-on impairments in most cases after 2013.

### The Regulatory Framework — 8 Cal. Code Regs. § 9805

The concrete rules for implementing these laws appear in 8 Cal. Code Regs. § 9805 (<https://www.dir.ca.gov/t8/9805.html>). This regulation adopts the Schedule for Rating Permanent Disabilities

(PDRS), which is the official document that turns your doctor's medical findings into a disability percentage and a dollar amount. The Schedule for Rating Permanent Disabilities (<https://www.dir.ca.gov/dwc/pdr.pdf>) is considered prima facie evidence of your permanent disability. "Prima facie" means the rating is presumed correct unless someone presents strong medical evidence showing it is wrong.

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## Part 2: The 34 Activities of Daily Living Explained

This section explains the specific daily activities that doctors must evaluate when rating your permanent impairment under the AMA Guides.

### What Are the 34 ADLs?

The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition (<https://www.ama-assn.org/practice-management/ama-guides/ama-guides-evaluation-permanent-impairment-overview>) lists 34 specific Activities of Daily Living in Table 1-2 on page 4. These are organized into six categories. Your doctor must consider how your injury affects these activities — not your ability to do your job.

**Self-Care and Personal Hygiene (7 activities):** Urinating, defecating, brushing teeth, combing hair, bathing, dressing yourself, and eating. These are the most basic tasks for taking care of your body. If you cannot button your shirt because of a hand injury, or you cannot bathe because of back pain, these limitations count.

**Communication (5 activities):** Writing, typing, seeing, hearing, and speaking. These cover your ability to communicate with others in everyday life — talking to your family, reading mail, or writing a note.

**Physical Activity (5 activities):** Standing, sitting, reclining, walking, and climbing stairs. These are often the most disputed ADLs in musculoskeletal injury cases (injuries to bones, muscles, joints, and the spine). Your ability to stand at the grocery store, walk to your car, or climb stairs at home all fall under this category.

**Sensory Function (5 activities):** Hearing, seeing, tactile feeling (touch), tasting, and smelling. The ability to feel temperature, detect pain, or smell smoke are safety-related functions the AMA Guides recognize as important.

**Nonspecialized Hand Activities (3 activities):** Grasping, lifting, and tactile discrimination (the ability to feel fine differences with your fingers). "Nonspecialized" means these are basic hand functions everyone needs — holding a cup, picking up objects, or feeling the texture of clothing — not job-specific skills.

**Travel and Sexual Function (9 activities):** Driving, riding, traveling by airplane, train, or car; and orgasm, ejaculation, lubrication, and erection. Travel ADLs affect your ability to get to appointments and visit family. Sexual function, while personal, is explicitly recognized by the AMA Guides as a legitimate measure of how an injury affects your quality of life.

***Important: Work activities, social participation, and recreational activities are deliberately excluded from this list. The AMA Guides measure medical impairment — not your job capacity. Your job capacity is addressed separately through occupational adjustments in the rating calculation.***

### How Doctors Assess the Degree of ADL Limitation

Your doctor does not simply count how many ADLs are limited. Instead, the doctor evaluates the overall severity and scope of your restrictions across all affected ADLs. The AMA Guides instruct doctors to consider four factors:

- Independence — Can you do the activity on your own, or do you need help?
- Appropriateness — Can you do the activity in a normal, safe way?
- Effectiveness — Can you complete the activity successfully?
- Sustainability — Can you do the activity repeatedly over time without worsening your condition?

A 20 percent WPI does not mean you can do 80 percent of the 34 ADLs without problems. It means that across all your activities, considering the type and degree of restriction, your doctor estimates the overall impact at 20 percent.

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## Part 3: How ADL Assessment Becomes Your Disability Rating

This section walks you through the five steps that turn your doctor's ADL-based findings into a permanent disability rating and a compensation amount.

### **Step 1: Your Doctor Assigns a Whole Person Impairment (WPI) Rating**

Your doctor examines you and assigns a WPI percentage using the AMA Guides chapter that matches your injury. For example:

- Back injuries use Chapters 15a and 15b (Spine), which rate conditions using the Diagnosis-Related Estimate (DRE) system. DRE categories range from Category I (0–3% WPI) to Category V (25–30% WPI), based on nerve involvement, surgery, and how much the condition limits standing, walking, bending, and other physical activity ADLs.
- Arm and hand injuries use Chapter 16 (Upper Extremity), rating motion loss, strength loss, and sensory loss that affect grasping, lifting, and tactile discrimination ADLs.
- Psychiatric injuries use Chapter 14, which employs the Global Assessment of Functioning (GAF) scale. Lower GAF scores mean greater functional limitation across multiple ADLs.

This first step is the foundation. Every error here cascades through all the following steps.

### **Step 2: Future Earning Capacity (FEC) Adjustment**

Your WPI is multiplied by 1.4 for injuries on or after January 1, 2013 under Cal. Lab. Code § 4660.1(b) (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660-1/>). This 40 percent increase reflects research showing that injured workers typically lose more earning power than the raw medical impairment number suggests.

For example, a 10% WPI becomes 14% after the FEC adjustment ( $10 \times 1.4 = 14$ ).

### **Step 3: Occupational Adjustment**

Your rating is adjusted based on the job you had when you were hurt. The Schedule for Rating Permanent Disabilities (<https://www.dir.ca.gov/dwc/pdr.pdf>) divides jobs into 45 occupational groups. A back injury affects a construction worker's earning capacity more than a desk worker's, so the construction worker receives a higher occupational adjustment. The adjustment uses an occupational variant (a letter from C to J, with F being average) to modify your rating up or down.

### **Step 4: Age Adjustment**

Your rating is further adjusted based on your age at the time of injury. Older workers receive higher ratings because they face greater difficulty retraining, adapting to modified work, and competing in the job market.

### **Step 5: Final Rating and Compensation**

The result is your final permanent disability rating — a percentage from 0% to 100%. This percentage corresponds to a fixed number of weeks of indemnity compensation (money paid to you), calculated at two-thirds of your average weekly earnings, subject to legal minimums and maximums. The Schedule contains charts showing exactly how many weeks of compensation each percentage is worth.

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## **Part 4: The Pain Add-On — The Three-Percent Cap**

This section explains how pain affects your ADL assessment and the legal limits on pain-based impairment ratings.

### **How the AMA Guides Rate Pain**

Chapter 18 of the AMA Guides rates pain disorders based on how much pain limits your ability to perform ADLs. Table 18-3 classifies pain into four levels:

- Class 1 (Mild): Your pain is mildly aggravated by daily activities. You can perform them with few changes.
- Class 2 (Moderate): You have moderate difficulty with daily activities. You must make significant changes — like moving to a ground-floor apartment or buying a car with automatic transmission.
- Class 3 (Moderately Severe): You can perform daily activities only with substantial changes. You cannot perform many routine activities, such as driving.

- Class 4 (Severe): You must get help from others for many daily activities (like preparing food or dressing), drastically change activities (like stopping bathing), or spend a very long time doing them (like 2 hours to get out of bed and dressed).

### The Three-Percent Maximum

Under the Schedule for Rating Permanent Disabilities (<https://www.dir.ca.gov/dwc/pdr.pdf>) and Cal. Lab. Code § 4660 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660/>), your body-system WPI rating (from Chapters 3–17 of the AMA Guides) may be increased by 0 to 3 percent if your pain causes functional limitations beyond what is already built into the standard rating. This three-percent cap applies regardless of how severe your pain is.

***Important: Even if you experience Class 4 severe pain requiring help with basic daily activities, the maximum increase to your scheduled rating is three percentage points. The maximum pain allowance for a single injury is 3% WPI, regardless of the number of impairments from that injury.***

While three percent sounds small, the difference between a 10% and 13% rating can mean approximately 50 additional weeks of disability payments — potentially tens of thousands of dollars.

### How Pain Credibility Is Evaluated

Disputes over pain-based ADL limitations often come down to credibility — whether your reported pain level matches the evidence. Doctors and judges consider:

- Objective findings: Does imaging (MRI, X-ray) or testing explain your pain? Pain backed by documented nerve compression is more credible than pain with normal imaging.
- Consistency: Do you report the same limitations to different doctors? If you tell one doctor you cannot sit for 30 minutes but sit through a one-hour exam without visible distress, your credibility may be questioned.
- Behavioral observations: Does your behavior during the exam match your reported pain? Grimacing, guarding, and protective movements support your report.
- Functional Capacity Evaluations (FCEs): If a standardized test shows you can do more than you reported, your credibility may be challenged.
- Surveillance evidence: If an insurance investigator records you doing activities you said you could not do, this can seriously damage your claim.

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## Part 5: Key Court Decisions You Should Know

This section covers the most important recent legal decisions that affect how ADLs are used in your case.

### Almaraz/Guzman — Your Right to Challenge the Standard Rating (2009–2010)

The Workers' Compensation Appeals Board's 2009 en banc decision in *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* ([https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ\\_Sep2009.pdf](https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ_Sep2009.pdf)) established a fundamental principle: the permanent disability rating schedule is presumed correct but can be challenged.

In the *Almaraz* case, a truck driver had a back injury and surgery. His doctor gave him a 12% WPI, but also said he could never return to truck driving and was permanently limited to light desk work. The WCAB agreed that the 12% rating did not capture his true level of impairment.

The Court of Appeal affirmed in *Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman)*, 187 Cal. App. 4th 808 (6th Dist. 2010), but set limits:

- A doctor may use different sections of the AMA Guides to reach a more accurate rating, but only in "extraordinary and complex cases."
- Any alternative rating must stay "within the four corners" of the AMA Guides — meaning the doctor must use recognized tables and methods from the Guides, not make up new ones.
- The alternative rating must be supported by substantial medical evidence — detailed explanation of why the standard approach does not accurately capture your ADL limitations.

**Note: "Substantial medical evidence" means evidence that is reasonable, credible, and of solid value. A doctor's opinion qualifies as substantial evidence when it is based on adequate information, sound reasoning, and proper methodology.**

### **Vigil v. County of Kern — Multiple Injuries and Synergistic Effects (2024)**

On June 10, 2024, the WCAB issued a landmark en banc decision in *Vigil v. County of Kern*, 90 Cal. Comp. Cases 686 (WCAB 2024) (<https://www.dir.ca.gov/wcab/EnBancdecisions2024/Vigil-Sammy.pdf>) that changed how multiple body-part injuries are rated together.

Normally, when you have injuries to more than one body part, the ratings are combined using the Combined Values Chart (CVC) rather than simply added together. The CVC reduces the total because it assumes your injuries overlap in how they affect your daily activities. *Vigil* clarified that you can challenge the CVC and have your ratings added instead if you prove one of two things:

**Pathway 1 — No Overlap:** Your injuries affect completely different ADLs. For example, a hearing loss (affects hearing ADL) and a finger amputation (affects grasping ADL) do not overlap, so addition is appropriate.

**Pathway 2 — Synergistic Amplification:** Your injuries affect the same ADLs, but the combination makes the limitation worse than either injury alone. For example, injuries to both hips create far more difficulty walking and climbing stairs than a single hip injury, because you cannot compensate by relying on the healthy side.

**Critical: The *Vigil* court held that simply saying "synergistic effect" is not enough. Your doctor must provide detailed analysis of:**

- Which specific ADLs are affected by each injury
- How the effects of each injury on the same ADL interact to make the limitation worse
- Why the Combined Values Chart does not accurately capture this amplified effect

The case was sent back for further medical analysis because the doctor's original opinion lacked this detail.

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## **Part 6: Medical Evaluators — QMEs, AMEs, and Treating Physicians**

This section explains who evaluates your ADL limitations and how each type of doctor's opinion is treated.

### **Qualified Medical Evaluators (QMEs)**

A Qualified Medical Evaluator (QME) is a doctor certified by the Division of Workers' Compensation (DWC) to examine injured workers and resolve medical disputes. When you and the insurance company disagree about your medical condition, either side can request a QME panel from the DWC Medical Unit (<https://www.dir.ca.gov/dwc/medicalunit/QualificationForQME.html>).

The DWC sends a panel of three doctors. Each side can remove one doctor from the panel for any reason (called a "strike"). The remaining doctor becomes your QME. The QME must:

- Review all your medical records and treatment history
- Take your history and examine you
- Issue a detailed report using the AMA Guides methodology
- Specifically assess your ADL limitations

QME opinions carry significant weight because the QME is supposed to be neutral — not hired by you or the insurance company.

### **Agreed Medical Evaluators (AMEs)**

An Agreed Medical Evaluator (AME) is a doctor that both you (usually through your attorney) and the insurance company agree to use instead of the QME panel process. AME reports are often viewed as highly persuasive because both sides accepted the doctor as qualified and neutral.

### **Treating Physicians**

Your treating physician — the doctor who has treated you from the beginning through maximum medical improvement (MMI) — has a unique advantage. This doctor has watched your condition over months or years and can credibly speak to your functional limitations based on direct, ongoing observation. Under Cal. Lab.

Code § 4061 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-1/section-4061/>), your treating physician must issue a Permanent and Stationary (P&S) report stating that your condition has stabilized and providing an impairment opinion.

Your treating physician's opinion is entitled to prima facie credibility because of their long-term familiarity with your case.

### **What Makes a Good ADL Assessment Report**

Whether from a QME, AME, or treating physician, a strong report should include:

- Specific ADLs identified: "This injury affects standing, walking, climbing stairs, and driving" — not just "patient has significant limitations."
- Degree of limitation stated: "Patient can stand maximum 15 minutes before severe pain" — not just "standing is limited."
- Basis explained: "Walking limitation is consistent with MRI showing severe spinal stenosis and clinical findings of neurogenic claudication."
- Connection to rating: "DRE Category III rating reflects the documented nerve compression and physical activity ADL limitations."

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## **Part 7: Challenging or Defending Your ADL-Based Rating**

This section covers the arguments available to you and to the insurance company when disputing ADL-based ratings.

### **Arguments That Support a Higher Rating (Applicant's Position)**

You may argue for a higher rating when:

- Your doctor provides detailed evidence that the standard AMA Guides rating does not capture your true ADL limitations. Under *Almaraz/Guzman* ([https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ\\_Sep2009.pdf](https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ_Sep2009.pdf)), this is your right if supported by substantial medical evidence.
- Your work restrictions (documented by your doctor) significantly exceed what the standard rating implies. For example, if your doctor says you can never return to your prior occupation and are limited to sedentary work, this suggests greater disability than a low WPI rating indicates.
- You have multiple injuries that interact to amplify your ADL limitations beyond what the Combined Values Chart predicts. Under *Vigil v. County of Kern*, 90 Cal. Comp. Cases 686 (WCAB 2024) (<https://www.dir.ca.gov/wcab/EnBancdecisions2024/Vigil-Sammy.pdf>), you can argue for addition rather than combination of impairment ratings.

### **Arguments That Support the Standard Rating (Defense Position)**

The insurance company may defend the standard rating by arguing:

- The Schedule for Rating Permanent Disabilities is presumed correct, and you have the burden to prove otherwise with substantial medical evidence.
- The standard AMA Guides methodology already accounts for your ADL limitations. Only "complex or extraordinary cases" justify deviation, per *Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman)*, 187 Cal. App. 4th 808 (6th Dist. 2010).
- Your reported ADL limitations are contradicted by objective evidence — FCE results, surveillance video, or inconsistent statements to different doctors.
- The AMA Guides deliberately exclude work activities from ADL assessment. Your inability to return to your prior job does not automatically mean your WPI should be higher.
- The three-percent pain cap reflects a legislative policy decision that limits subjective pain complaints from driving excessive ratings.

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## **Part 8: Dispute Resolution and Appeals**

This section explains what to do if you disagree with your ADL-based rating and how to protect your rights through the appeals process.

### Objecting to a QME Report

If you believe the QME's report has errors or gaps in the ADL assessment, you can:

- Request that the QME review additional medical records not available during the initial exam
- Submit supplemental written questions asking the QME to clarify their ADL analysis
- Request a supplemental evaluation if significant new evidence becomes available (such as a recent FCE)

Be specific in your objections. For example: "The QME failed to assess the applicant's capacity for standing and walking, noting only 'patient reports back pain' without specifying the degree of limitation or reconciling the patient's report with objective findings."

### Appealing to the Workers' Compensation Appeals Board (WCAB)

If the Workers' Compensation Judge (WCJ) rules against you, you can appeal to the Workers' Compensation Appeals Board ([https://www.dir.ca.gov/wcab/wcab\\_enbanc.htm](https://www.dir.ca.gov/wcab/wcab_enbanc.htm)). The WCAB reviews whether the judge made legal errors and whether the decision is supported by substantial evidence.

To build a strong appeal on ADL issues:

1. Make sure your medical reports specifically address ADLs with detail. If they do not, request supplemental questions or evaluations before the trial ends.
2. Obtain detailed testimony from your treating physician or from you personally about specific ADL limitations, supported by objective evidence where possible.
3. Directly respond to the insurance company's arguments about ADL credibility, objective findings, and FCE results.
4. Ensure the judge's written decision includes findings about the ADL evidence and the judge's reasoning. If the judge issues a decision without explaining their reasoning, the WCAB can send the case back.

### How Likely Are Different ADL Arguments to Succeed?

**Stronger cases (higher chance of success):** You have imaging-documented conditions (like nerve compression) that explain your limitations, your treating physician and QME both document specific ADL restrictions with objective support, and your doctor explains why the standard rating falls short using recognized AMA Guides methods.

**Moderate cases:** You seek the full three-percent pain increase, but imaging shows only mild changes and an FCE suggests you can do more than you reported. You may get some increase but risk getting less than the maximum.

**Weaker cases:** You seek to add multiple impairment ratings under Vigil, but your doctor provides only vague statements about "synergistic effects" without detailed analysis of specific ADLs. The Vigil framework requires precise ADL-by-ADL analysis, and vague opinions will likely fail.

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## Part 9: The 34 ADLs — Quick Reference Tables

**Table A: Activities of Daily Living (Table 1-2, AMA Guides 5th Edition)**

Category	Activities
Self-Care & Personal Hygiene	Urinating, Defecating, Brushing teeth, Combing hair, Bathing, Dressing, Eating
Communication	Writing, Typing, Seeing, Hearing, Speaking
Physical Activity	Standing, Sitting, Reclining, Walking, Climbing stairs
Sensory Function	Hearing, Seeing, Tactile feeling, Tasting, Smelling
Nonspecialized Hand Activities	Grasping, Lifting, Tactile discrimination
Travel & Sexual Function	Driving, Riding, Traveling by air/train/car, Orgasm, Ejaculation, Lubrication, Erection

**Table B: Pain Classification and ADL Impact (Table 18-3, AMA Guides 5th Edition)**

Pain Class	Your Daily Activities	What This Means
Class 1 (Mild)	Pain is mildly aggravated by activities	You can do most things with few changes
Class 2 (Moderate)	Moderate difficulty with activities	You must make significant changes (e.g., move to ground-floor apartment)
Class 3 (Moderately Severe)	Can do activities only with substantial changes	You cannot perform many routine activities like driving
Class 4 (Severe)	Must get help from others or drastically change activities	You need help dressing or preparing food; may take 2 hours to get out of bed

**Table C: Statutory Limits on Add-On Impairments (Injuries After Jan. 1, 2013)**

Condition	Can It Increase Your Rating?	Exceptions
Sleep dysfunction	No	Violent act or catastrophic injury
Sexual dysfunction	No	Violent act or catastrophic injury
Psychiatric disorder	No	Violent act or catastrophic injury
Pain (Chapter 18)	Yes, up to 3% WPI maximum	None — 3% cap applies to all cases

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## References

1. Cal. Lab. Code § 4660 — Schedule for Rating Permanent Disabilities (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660/>)
2. AMA Guides to the Evaluation of Permanent Impairment, 5th Edition — American Medical Association (2000) (<https://www.ama-assn.org/practice-management/ama-guides/ama-guides-evaluation-permanent-impairment-overview>)
3. Cal. Lab. Code § 4061 — Physician Reports and Permanent and Stationary Status (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-1/section-4061/>)
4. Cal. Lab. Code § 4660.1 — Permanent Disability Rating for Injuries After January 1, 2013 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660-1/>)
5. 8 Cal. Code Regs. § 9805 — Schedule for Rating Permanent Disabilities; Adoption and Amendment (<https://www.dir.ca.gov/t8/9805.html>)
6. Schedule for Rating Permanent Disabilities (2005 with 2013 Amendments) — Division of Workers' Compensation (<https://www.dir.ca.gov/dwc/pdr.pdf>)
7. Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District (En Banc Decision, 2009) — WCAB ([https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ\\_Sep2009.pdf](https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ_Sep2009.pdf))
8. Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman), 187 Cal. App. 4th 808 (6th Dist. 2010). [URL unavailable]
9. Vigil v. County of Kern, 90 Cal. Comp. Cases 686 (WCAB En Banc 2024) (<https://www.dir.ca.gov/wcab/EnBancdecisions2024/Vigil-Sammy.pdf.pdf>)
10. Ogilvie v. Workers' Compensation Appeals Board (En Banc Decision, 2009), 74 Cal. Comp. Cases 248 — WCAB ([https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABENBancOgilvieW\\_Sep2009.pdf](https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABENBancOgilvieW_Sep2009.pdf))
11. DWC Qualified Medical Evaluator (QME) Process Overview — Division of Workers' Compensation (<https://www.dir.ca.gov/dwc/medicalunit/QualificationForQME.html>)
12. DWC FAQs on QME Process — Division of Workers' Compensation (<https://www.dir.ca.gov/dwc/medicalunit/faqiw.html>)
13. DWC FAQs on the Permanent Disability Rating Schedule — Division of Workers' Compensation ([https://www.dir.ca.gov/dwc/faq/deu\\_faq.html](https://www.dir.ca.gov/dwc/faq/deu_faq.html))
14. California Workers' Compensation Guidebook for Injured Workers (2024) — Division of Workers' Compensation (<https://www.dir.ca.gov/injuredworkerguidebook/injuredworkerguidebook.html>)
15. Activities of Daily Living in the AMA Guides 5th Edition (DWC Educational Material) (<https://blog.rate-fast.com/wp-content/uploads/2021/01/6.5.20.DWC.QME.CE.ADL.pdf>)

16. AMA Guides 5th Edition Activities of Daily Living Overview — RateFast (<https://blog.rate-fast.com/the-ama-guides-5th-edition-dont-drive-without-a-roadmap/>)
17. WCAB En Banc Decisions — Division of Workers' Compensation ([https://www.dir.ca.gov/wcab/wcab\\_enbanc.htm](https://www.dir.ca.gov/wcab/wcab_enbanc.htm))
18. WCAB Significant Panel Decisions — Division of Workers' Compensation ([https://www.dir.ca.gov/wcab/wcab\\_panel.htm](https://www.dir.ca.gov/wcab/wcab_panel.htm))
19. Vigil En Banc Decision and CVC Rebuttal (2024) — JD Supra (<https://www.jdsupra.com/legalnews/wcab-issues-en-banc-decision-providing-9163250/>)
20. Impact of Vigil Decision on QMEs in California — OrthoLegal Group (<https://ortholegalgroup.com/impact-of-the-vigil-decision-on-qmes-in-californias-workers-compensation-system/>)
21. Vigil Decision Defense Perspective — RJY Law (<https://www.rjylaw.com/examining-the-en-banc-decision-in-virgil-v-county-of-kern-a-defense-perspective-on-permanent-disability-and-apportionment/>)
22. Guzman v. Milpitas Unified School District (Court of Appeal Summary) — CCMPT (<https://ccmpt.com/ca-court-of-appeal-upholds-the-decision-in-almazguzman-case/>)
23. Laws, Regulations, and Court Decisions Related to Diminished Future Earning Capacity — IARP RehabPro (<https://iarp-rehabpro.scholasticahq.com/article/146885-laws-regulations-and-court-decisions-related-to-diminished-future-ear.pdf>)
24. SB 899 Topic Summary Report — Commission on Health and Safety and Workers' Compensation (<https://www.dir.ca.gov/chswc/SB899summary.html>)
25. Medical Treatment Utilization Schedule (MTUS) — Division of Workers' Compensation (<https://www.dir.ca.gov/dwc/mtus/mtus.html>)
26. DWC Physician's Guide to Medical Practice in California Workers' Compensation — Division of Workers' Compensation (<https://www.dir.ca.gov/dwc/medicalunit/toc.pdf>)
27. What Constitutes Substantial Medical Evidence in California (2025) — BPK Firm (<https://bpkfirm.com/what-constitutes-substantial-medical-evidence-in-california-1c-4628/>)
28. The Role of Medical Evidence in Workers' Compensation Cases (2025) — Katnik Law (<https://katniklaw.com/the-role-of-medical-evidence-in-workers-compensation-cases/>)
29. Workers' Compensation Dispute Resolution Process in California — Dascanio Law (<https://dascaniolaw.com/workers-compensation-dispute-resolution-process-in-california/>)
30. Permanent Disability in California Workers' Compensation: How It Works (2025) (<https://workerscompensationfresno.ca.com/permanent-disability/>)
31. Understanding California's Permanent Disability Chart (2025) — Visionary Law Group (<https://visionarylawgroup.com/california-permanent-disability-money-chart/>)
32. Permanent Disability Ratings in California: How They Work (2025) — Employees First Labor Law (<https://employeesfirstlaborlaw.com/permanent-disability-ratings-in-california-workers-comp-how-they-work-and-what-theyre-worth/>)
33. GAF Score: Psychiatric Injury Workers Compensation Guide (2025) — Work Injury Help (<https://www.workinjuryhelp.com/gaf-score-meaning-what-you-need-to-know/>)
34. Evaluation of Activities of Daily Living: Current Insights and Future Directions — NIH/NCBI (<https://pmc.ncbi.nlm.nih.gov/articles/PMC12215002/>)
35. 8 Cal. Code Regs. § 55 — Continuing Education for Qualified Medical Evaluators (<https://www.dir.ca.gov/t8/55.html>)
36. DWC QME Competency Examination Information Booklet — Division of Workers' Compensation (<https://www.dir.ca.gov/dwc/medicalunit/qmeinformationbooklet.pdf>)
37. Apportionment in California Workers' Compensation: Case Law Updates (July 2024) — PBW Law (<https://www.pbw-law.com/apportionments/apportionment-case-law-update-july-2024/>)

# Activities of Daily Living Assessment in California Workers' Compensation: Legal and Practice Analysis

## (PART-B LEGAL ANALYSIS)

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# Activities of Daily Living Assessment in California Workers' Compensation: Comprehensive Legal and Practice Analysis

## Executive Summary

This report provides a comprehensive analysis of how Activities of Daily Living (ADLs) are assessed, weighted, and applied in California workers' compensation permanent disability determinations under the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, 5th Edition.[1][4][4] The integration of ADL assessment into permanent disability calculations represents one of the most consequential-and frequently disputed-elements of California's workers' compensation system, directly determining the financial compensation injured workers receive for work-related injuries with permanent consequences. The AMA Guides establish that whole person impairment (WPI) percentages are designed to estimate the impact of an impairment on an individual's overall ability to perform Activities of Daily Living, excluding work-related activities and social participation.[2][5] However, the exclusion of work activities from formal ADL assessment has created a persistent tension in California law between medical evaluation standards and compensation adequacy, a tension that courts have attempted to resolve through doctrines like Almaraz-Guzman alternative rating and the more recent Vigil decision on synergistic impairments.[10][18][51]

The analysis reveals that evaluating physicians (treating physicians, Qualified Medical Evaluators, and Agreed Medical Evaluators) bear the responsibility to assess the degree of functional restriction in 34 specifically identified ADLs, organized into six functional categories: self-care and personal hygiene, communication, physical activity, sensory function, nonspecialized hand activities, travel, and sexual function.[2][5][9] This assessment must consider not merely the number of restricted activities but the overall severity and scope of restriction, evaluating independence, appropriateness, effectiveness, and sustainability as objective criteria.[5][5] The permanent disability rating calculation then adjusts the WPI for diminished future earning capacity using a statutory adjustment factor (1.4 for injuries on or after January 1, 2013), followed by occupational and age adjustments under Labor Code Section 4660.1.[4][24] Key developments in recent case law-particularly the Vigil v. County of Kern en banc decision issued in 2024-have clarified that impairments affecting multiple body parts may be added rather than combined using the Combined Values Chart when applicants establish through substantial medical evidence that the impact of each impairment on overlapping ADLs either does not overlap or creates a synergistic amplification effect.[32][51] This report addresses the statutory framework, regulatory implementation, evaluation methodology, dispute standards, and practical considerations for injured workers, medical evaluators, and practitioners navigating this complex and high-stakes area of California workers' compensation law.

## I. Cover Page Information

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### III. Legal Framework: Statutes, Regulations, and Foundational Authorities

#### Statutory Foundation: Labor Code Section 4660 and Section 4660.1

The foundation for ADL-based permanent disability assessment in California rests on [Labor Code Section 4660][4], as substantially amended by Senate Bill 899 effective April 19, 2004.[33] Labor Code Section 4660(a) mandates that in determining permanent disability percentages, account shall be taken of three factors: the nature of the physical injury or disfigurement, the occupation of the injured employee, and the employee's age at the time of injury, "consideration being given to" the employee's diminished future earning capacity.[4][24] Critically, Section 4660(b)(1) specifies that the "nature of the physical injury or disfigurement" shall incorporate "the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) with the employee's whole person impairment, as provided in the Guides." [4][4] This statutory language creates a binding requirement that evaluating physicians apply the AMA Guides as the methodology for establishing baseline impairment, which the Guides define in terms of the impact on Activities of Daily Living.

[Labor Code Section 4660.1][4][4], effective January 1, 2013, further refined the permanent disability rating methodology for injuries occurring after that date. Under Section 4660.1(b), the WPI rating derived from the AMA Guides is then multiplied by an adjustment factor of 1.4 to convert impairment into a measure of diminished future earning capacity.[4][4] This 40 percent adjustment reflects the Legislature's determination that wage loss outcomes for injured workers typically exceed the baseline AMA Guides ratings, intended to provide compensation aligned with empirical earnings loss data.[26] The schedule of age and occupational modifiers must "promote consistency, uniformity, and objectivity," [4][4] establishing a regulatory framework within which individual variations in ADL impact can be assessed while maintaining statewide predictability.

Critically, Section 4660.1(c) imposes a significant limitation on certain add-on impairments: for injuries occurring on or after January 1, 2013, "the impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, arising out of a compensable physical injury shall not increase." [4][4] This statutory cap means that sleep dysfunction and sexual dysfunction—two of the fourteen ADL categories recognized by the AMA Guides—cannot be rated as separate impairments when they arise from a physical injury. However, Section 4660.1(c)(2) creates two exceptions: (A) if the compensable psychiatric injury resulted from being a victim of a violent act or direct exposure to a significant violent act, or (B) if there is a catastrophic injury including loss of a limb, paralysis, severe burn, or severe head injury.[4][4] These exceptions recognize that certain injuries may legitimately warrant psychiatric component ratings beyond the baseline physical impairment assessment.

## Regulatory Framework: 8 California Code of Regulations Section 9805

The concrete implementation of Labor Code Section 4660 appears in [8 California Code of Regulations Section 9805][13][16], which incorporates by reference the Schedule for Rating Permanent Disabilities based on the AMA Guides 5th Edition.[13][16] The Division of Workers' Compensation Administrative Director adopted this schedule effective January 1, 2005, with amendments addressing the 2013 changes to Section 4660.1.[13][16] The regulation provides that the Schedule shall be amended by the Administrative Director at least once every five years, creating a regulatory framework designed to remain responsive to medical advances and empirical data on earnings loss.[13][16] Importantly, Section 9805 establishes that the Schedule is "prima facie evidence" of permanent disability, meaning the scheduled rating is presumptively correct but rebuttable upon presentation of substantial medical evidence.[13][16][21]

The Schedule for Rating Permanent Disabilities—a document exceeding seventy pages—operationalizes ADL assessment through a multi-step methodology.[1] The first step identifies the appropriate impairment number for the body part or organ system involved, drawing from AMA Guides chapters 3 through 17 covering specific organ systems.[1][1] The second step assigns a whole person impairment (WPI) rating based on medical findings within the relevant AMA Guides chapter.[1][1] These WPI ratings are fundamentally ADL-anchored; the AMA Guides explicitly state that WPI percentages are designed to estimate the impact on the individual's overall ability to perform Activities of Daily Living.[2][5] The third step applies the Future Earning Capacity (FEC) adjustment factor (1.4 for post-2013 injuries), converting the non-empirical medical impairment rating into an earnings-based measure.[1][1] The fourth and fifth steps apply occupational and age modifiers derived from regulatory tables, recognizing that the same impairment may have differential impact on earning capacity depending on the worker's job classification and age at injury.[1][1]

The American Medical Association Guides, 5th Edition: Foundational Medical Authority

The [AMA Guides to the Evaluation of Permanent Impairment, 5th Edition][59] serve as the foundational medical authority for all impairment assessment in California workers' compensation.[1][4][4] Published in 2000, the 5th Edition departed from prior editions by explicitly anchoring impairment ratings to functional limitation in Activities of Daily Living rather than pure anatomic loss.[2][5][9] Chapter 1 of the AMA Guides, titled "Philosophy, Purpose, and Appropriate Use of the Guides," establishes the conceptual framework: impairment is defined as a loss of function reflecting severity for a given health condition, expressed as a percentage estimate of the degree of associated limitations in terms of Activities of Daily Living.[2][5] The Guides emphasize that the impairment rating does not reflect work capacity, social participation, or economic impact—those are properly the domain of disability determination and compensation policy, not medical evaluation.[2][5][44]

Table 1-2 of the AMA Guides, found on page 4 of the philosophical introduction, presents the 34 Activities of Daily Living referenced throughout the rating systems.[2][5][9] These ADLs are organized into six broad categories: (1) Self-care and personal hygiene (urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating); (2) Communication (writing, typing, seeing, hearing, speaking); (3) Physical activity (standing, sitting, reclining, walking, climbing stairs); (4) Sensory function (hearing, seeing, tactile feeling, tasting, smelling); (5) Nonspecialized hand activities (grasping, lifting, tactile discrimination); and (6) Travel (driving, riding, traveling by airplane, train, or car) and sexual function (orgasm, ejaculation, lubrication, erection).[2][5][9] Conspicuously absent from this ADL list are work-specific activities, social participation, and recreational activities—a deliberate exclusion reflecting the Guides' purpose of measuring medical impairment rather than occupational capacity.[2][5][9]

The AMA Guides establish that impairment ratings within each organ system chapter must reflect the degree to which the condition impacts the ability to perform the relevant ADLs identified for that body system.[2][5][44] For example, the spine chapters (Chapters 15a and 15b, addressing the lumbar, thoracic, and cervical spine) specify Diagnosis-Related Estimates (DRE) categories that incorporate ADL limitations like the ability to sit, stand, walk, and bend—all activities directly tied to Table 1-2.[5][9] Similarly, upper extremity impairments (Chapter 16) assess the capacity to perform grasping, lifting, and tactile discrimination—nonspecialized hand activities from Table 1-2.[5] The psychiatric chapter (Chapter 14, for primary psychiatric injuries) rates conditions using the Global Assessment of Functioning (GAF) scale, which explicitly measures the individual's ability to perform work, schooling, and social functioning—though notably, occupational impairment is not a permissible basis for increasing ratings beyond the GAF-derived percentage for injuries occurring after January 1, 2013, per Section 4660.1(c).[35][49]

#### IV. Current Legal Landscape and Recent Developments (2024-2026)

##### The Vigil v. County of Kern En Banc Decision (2024): Reshaping ADL-Based Multiple Impairment Analysis

On June 10, 2024, the California Workers' Compensation Appeals Board issued a landmark en banc decision in [Vigil v. County of Kern (ADJ11201607 and ADJ11201608)][32][51][66] that fundamentally clarified-and in certain respects limited-the applicant's burden of proof when seeking to rebut the Combined Values Chart (CVC) through ADL-based analysis. The en banc decision was issued after reconsideration, clarifying a prior panel decision that had been criticized as insufficiently rigorous in requiring ADL analysis.[32][51] The WCAB held En Banc that the Combined Values Chart in the Permanent Disability Rating Schedule may be rebutted and impairments may be added (rather than combined) where an applicant establishes the impact of each impairment on Activities of Daily Living and demonstrates either: (a) there is no overlap between the effects on ADLs as between the body parts rated, or (b) there is overlap, but the overlap increases or amplifies the impact on the overlapping ADLs.[32][51][66]

The Vigil case itself involved a maintenance painter who sustained injuries to both hips and the lumbar spine, subsequently undergoing bilateral hip replacement surgeries.[32][51][66] A Qualified Medical Evaluator (QME) assigned 15 percent whole-person impairment to each hip and 7 percent WPI to the lumbar spine.[32][51] The QME opined that the applicant would have "significantly more limitations" after both hips were replaced compared to a person with one normal hip and one post-surgical hip, concluding that the impairments should be added rather than combined under the CVC.[32][51][66] However, the WCAB found that the QME "provided little analysis in support of this conclusion" and failed to specifically address the impacts on the applicant's ADLs and explain why the disability in the two hips combined in a way to increase the impact on overall ADLs.[32][51][66]

The critical holding in Vigil is that "synergy" is not a magic word invoking the right to add impairments.[32][51][66] Rather, where an applicant seeks to rebut the CVC, they must establish: (1) The ADLs impacted by each impairment to be added, and (2) Either: (a) The ADLs do not overlap, or (b) The ADLs overlap in a way that increases or amplifies the impact on the overlapping ADLs.[32][51][66] The WCAB defined synergy as "the interaction of two or more agents or forces so that their combined effect is greater than the sum of their individual effects, or cooperative interaction among groups that creates an enhanced combined effect." [32][51][66] This definition grounded synergy in functional reality: two impairments overlap with one another in their effect on ADLs to the extent that they amplify one another to cause further impairment than what is anticipated in the AMA Guides.[32][51][66] The decision rescinded the trial court's decision and remanded the matter for further development of the record, instructing the court to require more detailed ADL analysis.

The Vigil decision's significance lies in its practical effect: it raised the evidentiary bar for applicants seeking to overcome the presumptive correctness of the CVC, requiring detailed physician analysis of specific ADLs and their interaction, not merely conclusory statements about synergistic effects.[32][51][66] For defense counsel and claims administrators, it provides a roadmap for challenging addition-based ratings that lack granular ADL analysis. For applicants' counsel, it establishes a clear framework-focus on specific overlapping ADLs and explain with medical precision how the interaction of multiple impairments amplifies functional limitation beyond what the Combined Values Chart anticipates.

##### Almaraz/Guzman II Principles in Current Practice (2024-2026)

The Almaraz and Guzman en banc decisions from 2009, clarified on reconsideration in September 2009, remain controlling authority establishing that the Permanent Disability Rating Schedule (and the AMA Guides WPI component within it) is prima facie evidence but rebuttable.[10][18][21] A party rebutting the schedule bears the burden of presenting substantial medical evidence demonstrating that the standard AMA Guides rating does not accurately reflect the injured worker's true impairment.[10][18][21][23] The Court of Appeal's decision in Almaraz II (August 2010, 6th District) affirmed that a physician may incorporate different sections of the AMA Guides to determine the applicant's whole person impairment, provided that the physician applies the Guides "as intended" and "as written" and that the deviation from standard rating is supported by substantial evidence.[18]

Importantly, the court indicated that a physician may go outside the chapter most appropriate to an injured worker's injury only in "extraordinary and complex cases," not as a routine methodology.[18][23] In typical cases, physicians should employ the AMA Guides' standard chapter and section applicable to the specific

injury; deviation from that path requires clear, detailed explanation of why the standard approach does not fairly and accurately reflect the injured worker's impairment.[18][23] The decision rejected the device of "analogizing" impairments (for example, stating that a 25 percent loss of function of an upper extremity equals the AMA rating for the entire upper extremity), finding such logic to lack any basis in the Guides' methodology.[7] Instead, if a physician determines that the standard rating is inadequate, they must identify which additional AMA Guides sections, tables, or methods more accurately capture the impairment, explain the medical reasoning supporting that choice, and justify the deviation through reference to Guides-based elements and clinical findings.

In 2024-2026 practice, Almaraz-Guzman principles remain actively litigated in cases involving significant pain components, spinal impairments with neurologic involvement, and conditions where the standard Diagnosis-Related Estimate (DRE) category or other standard rating method appears to undervalue functional limitation. The framework requires that any alternative rating, even if grounded in different Guides sections, must stay "within the four corners of the Guides"-relying on recognized tables, methodologies, or rating systems found within the AMA Guides 5th Edition.[8][8] This constraint, imposed to maintain consistency and prevent arbitrary deviation, remains a powerful tool for defense counsel to challenge alternative ratings that lack clear Guides-based support.

#### Federal Register and Administrative Developments (2024-2026)

The Division of Workers' Compensation has continued to maintain the permanent disability rating schedule through periodic amendments and clarifications.[13][16] As of the current research date (March 2026), no fundamental overhaul of the ADL-based rating system has been implemented, though the DWC regularly updates the Schedule for Rating Permanent Disabilities in response to case law developments and administrative clarifications.[13][16] The Medical Treatment Utilization Schedule (MTUS), while not directly governing permanent disability ratings, influences impairment assessments through evidence-based treatment guidelines that shape the clinical findings upon which physicians base impairment opinions.[70] Recent MTUS updates (through 2026) have emphasized documentation of objective findings and functional outcomes, indirectly supporting more rigorous ADL-based analysis in impairment reports.

#### V. The AMA Guides 5th Edition: Comprehensive ADL Methodology and Assessment Standards

##### The 34 Activities of Daily Living: Organization and Functional Categories

The AMA Guides 5th Edition defines impairment through the lens of functional limitation in Activities of Daily Living.[2][5][9] The 34 identified ADLs, presented in Table 1-2 on page 4 of the Guides, represent a functional inventory designed to capture the full range of non-work, non-social activities necessary for independent living.[2][5][9] Understanding each category and the specific activities within it is essential for both medical evaluators and legal practitioners challenging or defending ADL-based impairment ratings.

The first functional category, Self-Care and Personal Hygiene, encompasses seven specific activities: urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, and eating.[2][5][9][5] These activities represent the foundational tasks required for maintaining basic bodily cleanliness, elimination, and nutrition. Impairments affecting self-care-such as severe arthritis limiting the ability to button clothing or severe back pain restricting the ability to bathe-are among the most immediately apparent to injured workers and often form the basis of credible ADL limitation testimony. The AMA Guides recognize that self-care impairments have high semantic validity: if a worker cannot dress themselves, cannot bathe, or cannot eat without significant pain or assistance, the impairment is objectively observable and difficult to dispute.

The second category, Communication, includes writing, typing, seeing, hearing, and speaking.[2][5][9][5] Impairments in communication ADLs arise from injuries affecting the hands (limiting writing and typing), the eyes (limiting seeing), the ears (limiting hearing), or the voice/throat (limiting speaking). Communication impairments extend beyond work-related limitations-an injured worker's ability to communicate with family, participate in healthcare decisions, and engage in community activities all depend on these ADLs. A worker with severe hand tremor impairing the ability to write or type, or a worker with hearing loss impairing the ability to hear and understand speech, experiences genuine functional limitation in non-work contexts.

The third category, Physical Activity, encompasses the broadest range of ADL functions: standing, sitting, reclining, walking, and climbing stairs.[2][5][9][5] These activities form the foundation of occupational capacity but are defined in the AMA Guides purely in functional terms-the ability to maintain various body

postures and to ambulate-without reference to work context. An injured worker's ability to stand for a period of time, sit for extended periods, walk different distances, and climb stairs are foundational to activities like grocery shopping, attending appointments, caring for family members, and participating in community life. Impairments in physical activity ADLs are frequently central to disputes in musculoskeletal injury cases, where workers claim significant limitations in standing, walking, or climbing stairs and employers argue that functional capacity evaluations or surveillance evidence contradicts those claims.

The fourth category, Sensory Function, includes hearing, seeing, tactile feeling, tasting, and smelling.[2][5][9][5] While some of these senses seem remote from everyday activity (tasting and smelling), they are included because the AMA Guides recognize the role of sensation in safety, navigation, and quality of life. A worker who cannot feel temperature, cannot detect pain (important for avoiding injury), or cannot smell smoke or gas is at increased risk and experiences genuine functional limitation. Sensory impairments, particularly in vision and hearing, directly affect the ability to navigate environments safely, understand communications, and engage in social activities.

The fifth category, Nonspecialized Hand Activities, specifies grasping, lifting, and tactile discrimination.[2][5][9][5] "Nonspecialized" is important: these are basic hand functions, not occupational skills. A worker's ability to grasp objects (whether a toothbrush, a cup, or a piece of paper), to lift objects of reasonable weight, and to perceive fine tactile differences (necessary for tasks like threading a needle or feeling the texture of clothing) are basic ADLs independent of work. Hand injuries-crush injuries, nerve injuries, arthritis-frequently impair these ADLs significantly.

The sixth category combines Travel and Sexual Function: riding, driving, flying, traveling by airplane/train/car (travel); and orgasm, ejaculation, lubrication, erection (sexual function).[2][5][9][5] Travel ADLs are clearly relevant to non-work activities: the ability to drive to appointments, to use public transportation, or to travel for personal reasons. Sexual function, while sometimes awkward to discuss in legal proceedings, is explicitly recognized by the AMA Guides as a significant ADL affecting quality of life and intimate relationships. Injuries to the lumbar spine, pelvis, or lower extremities may impair sexual function; spine surgery may create erectile dysfunction as a side effect; chronic pain may reduce desire and capacity for sexual activity. The inclusion of sexual function in the ADL inventory reflects the medical profession's recognition that bodily function in intimate contexts is a legitimate measure of impairment.

#### Impairment Severity and the ADL-Impairment Relationship

The AMA Guides establish a direct relationship between the degree of ADL limitation and the impairment percentage assigned.[2][5] Within each organ system chapter, the Guides provide rating classes or categories (often ranging from Class I to Class IV or DRE Category I to V) that reflect varying degrees of ADL impact.[2][5][44] For example, in the spine chapters, the Diagnosis-Related Estimate (DRE) system creates five categories based on anatomic pathology and functional limitation (radiculopathy with or without surgery, myelopathy, etc.), with each category associated with a range of WPI percentages and guidance on which ADLs are typically affected at that severity level.[5][7][44]

The AMA Guides page 4 emphasizes that the WPI percentages listed in the Guides "estimate the impact of the impairment on the individual's overall ability to perform activities of daily living." [2][5] This means the impairment rating is a proxy-a medical estimate-of functional limitation across the 34 ADLs, not a measurement of the specific number of restricted ADLs or the severity of restriction in particular activities.[2][5] A 20 percent WPI does not mean the worker can perform 80 percent of the 34 ADLs without limitation; rather, it means that across all activities, considering the type and degree of restriction, the overall impact is estimated at 20 percent.

#### Pain Assessment and ADL Impact: The Three-Percent Limitation Under Section 4660.1(c)

Chapter 18 of the AMA Guides addresses pain disorders and pain-related impairment, establishing a separate methodology for rating conditions where pain is the primary or predominant limiting factor.[2][5][1] The Guides define pain-related impairment through the lens of ADL limitation: the degree to which pain limits the individual's ability to perform self-care, physical activity, traveling, and other activities.[2][5][5] Table 18-3 in the AMA Guides classifies pain from mild (Class 1) through severe (Class 4), with each class associated with described ADL limitations.[2][5][5][1]

Mild pain (Class 1) is described as "Individual's pain is mildly aggravated by performing ADL; is able to perform them with few modifications." [2][5][5][1] Moderate pain (Class 2) is described as "Individual has moderate difficulty managing ADL; must make significant modifications in order to perform them (e.g., move to a ground floor apartment, buy a car with automatic transmission)." [2][5][5][1] Moderately Severe pain (Class 3) is described as "Individual can perform ADL only with substantial modifications; unable to perform many routine activities (e.g., driving a car)." [2][5][5][1] Severe pain (Class 4) is the most limiting: "Individual must either get help from others for many ADL (e.g., preparing food, dressing), modify them drastically (e.g., stop bathing), or spend an inordinate amount of time accomplishing them (e.g., 2 hours to get out of bed and dressed)." [2][5][5][1]

However, the permanent disability rating schedule limits the use of pain-based ratings. Under [Labor Code Section 4660.1(c) and the corresponding Schedule provisions][1], a whole person impairment rating based on the body or organ rating system of the AMA Guides (Chapters 3 through 17) may be increased by 0 percent up to 3 percent WPI if the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating in Chapters 3-17.[1] This three-percent cap means that even if an injured worker experiences Class 4 severe pain with dramatic ADL limitation, the maximum increase to the scheduled rating is three percentage points.[1] The maximum allowance for pain resulting from a single injury is 3 percent WPI regardless of the number of impairments resulting from that injury.[1]

Moreover, for injuries occurring on or after January 1, 2013, sleep dysfunction and sexual dysfunction—two of the recognized ADLs—cannot be separately rated when they arise from a physical injury.[4][4] Only if the compensable psychiatric injury resulted from a violent act or direct exposure to significant violence, or from a catastrophic injury (loss of a limb, paralysis, severe burn, severe head injury), may psychiatric impairment be rated separately.[4][4] This statutory limitation recognizes legislative concern about allowing subjective complaints of sleep or sexual dysfunction to drive ratings beyond the scheduled system.

## VI. Integration of ADL Assessment into Permanent Disability Rating Calculations

### The Multi-Step Permanent Disability Calculation Framework

The permanent disability rating calculation in California involves five integrated steps, each of which depends on accurate ADL-based impairment assessment.[1][1][24][37] Understanding this process is essential for evaluators, practitioners, and injured workers seeking to understand how ADLs translate into compensation amounts.

#### Step One: Whole Person Impairment (WPI) Rating Under the AMA Guides

The first step requires the evaluating physician to assign a whole person impairment rating based on medical findings and the applicable AMA Guides chapter(s).[1][1][24][37] This WPI rating is fundamentally ADL-anchored; the physician must consider how the medical condition affects the individual's capacity to perform the relevant Activities of Daily Living identified within the applicable chapter.[1][2][5][1] For example, a physician evaluating a back injury uses Chapter 15a or 15b (Spine), selecting a Diagnosis-Related Estimate (DRE) category based on anatomic pathology (e.g., HNP, radiculopathy, myelopathy) and clinical findings.[7][44] The DRE categories range from Category I (no significant anatomic injury with radiculopathy) to Category V (myelopathy), with WPI ranges of 0-3 percent, 5-8 percent, 10-13 percent, 15-18 percent, and 25-30 percent respectively.[7][44] Within each range, the physician selects a specific percentage based on the degree of ADL limitation—how significantly the condition impacts the individual's ability to sit, stand, walk, bend, climb stairs, and perform other physical activities.

For upper extremity impairments, Chapter 16 provides tables specifying WPI ratings based on the degree of motion loss, strength loss, or sensory loss in specific joints and body parts.[5] A worker with 50 percent loss of motion in the wrist might receive a WPI rating in the 10-15 percent range, depending on whether the loss affects the dominant or non-dominant hand and how significantly it impairs grasping, lifting, and tactile discrimination.[5] The rating reflects the degree to which these hand-function ADLs are compromised.

For psychiatric injuries, Chapter 14 or the Global Assessment of Functioning (GAF) scale is used, rating the individual's psychological, social, and occupational functioning on a continuum from 1 to 100.[35][49] A GAF score below 70 is associated with impairment; lower scores reflect greater functional limitation across multiple ADLs relevant to psychological health (ability to work, maintain relationships, engage in self-care,

etc.).[35][49] However, as noted, for injuries after January 1, 2013, psychiatric impairment arising from physical injuries cannot increase the rating unless specific statutory exceptions apply.[4][4]

#### Step Two: Future Earning Capacity (FEC) Adjustment

Once the WPI rating is established, it is adjusted for Future Earning Capacity (FEC) using a numeric formula based on empirical data.[1][1][24][37] For injuries on or after January 1, 2013, the calculation is straightforward: the WPI percentage is multiplied by 1.4 (a 40 percent increase).[1][1][24][37][4] This adjustment factor reflects the Legislature's determination that actual wage loss for injured workers typically exceeds the medical impairment rating by approximately 40 percent, based on empirical studies of earnings loss across injury categories.[24][26] The result is the FEC-adjusted rating, which represents the estimated impact on diminished future earning capacity.

For injuries occurring before January 1, 2013 (governed by Section 4660, not Section 4660.1), the FEC adjustment is more complex, using a formula with category-specific adjustment factors ranging from 1.1 to 1.4 depending on the type of injury.[1][1][24][26] However, the conceptual foundation is the same: the medical impairment rating is converted to an earnings-based measure, reflecting the principle that permanent disability is fundamentally about diminished capacity to earn.

#### Step Three: Occupational Adjustment

After FEC adjustment, the rating is adjusted for the worker's occupation at the time of injury.[1][1][24][37] The Schedule for Rating Permanent Disabilities divides the labor market into 45 numbered occupational groups, each characterized by the typical demands on specific body parts.[1][1][34][34] A construction carpenter (occupational group 110) places high demands on the back, shoulders, and knees; a desk worker or administrative professional (occupational group 403) places minimal demands on those body parts. The same back impairment-say, a DRE Category III with 11 percent WPI-will result in a different occupational-adjusted rating depending on whether the worker is a construction carpenter or a desk worker, because the degree to which the impairment affects future earning capacity varies with occupational demands.

The occupational adjustment uses an "occupational variant" (a letter ranging from C to J, with F representing average demands) to modify the rating up or down depending on whether the injury affects a body part critical to the occupation or relatively unimportant to it.[1][1][34][34] For example, a hand injury affecting a surgeon or pianist would be adjusted upward because the hand is critical to their occupational capacity; the same hand injury affecting a manager would receive minimal occupational adjustment.

#### Step Four: Age Adjustment

The final adjustment factors in the degree of age at the time of injury.[1][1][24][37] Older workers, injured at advanced age, receive higher permanent disability ratings than younger workers with identical impairments, based on the premise that older workers face greater difficulty retraining, adapting to modified work, and competing in the labor market.[1][1] This age adjustment recognizes that diminished future earning capacity is greater for a 55-year-old with a 20 percent WPI than for a 25-year-old with identical impairment.

#### Step Five: Calculation of Final Permanent Disability Rating and Indemnity Weeks

The result of these four adjustments is the final permanent disability rating percentage, ranging from 0 percent to 100 percent.[1][1][24][37] The permanent disability rating corresponds to a fixed number of weeks of indemnity compensation, paid at the worker's compensation rate (two-thirds of average weekly earnings, subject to statutory minimums and maximums).[1][1][24][37] The Schedule for Rating Permanent Disabilities contains indemnity charts that specify the number of weeks payable for each percentage point of disability.[1][1] For example, a worker with a 20 percent permanent disability rating might receive compensation for 100 weeks; a worker with a 50 percent rating might receive 300 weeks or more.

This framework demonstrates that ADL assessment at Step One directly cascades through all subsequent calculations. An error in the baseline WPI rating-for example, failing to adequately assess the degree of ADL limitation-will result in an incorrect FEC adjustment, occupational adjustment, age adjustment, and ultimately, an incorrect permanent disability rating and indemnity award. This is why ADL assessment is not peripheral to permanent disability determination; it is foundational.

#### ADL Assessment and Credibility: How Physicians Assess the Degree of ADL Limitation

Physicians evaluating permanent disability must assess not merely which ADLs are limited, but the degree of limitation in each relevant activity.[2][5][5][44] The AMA Guides emphasize that physicians should employ clinical judgment informed by objective findings (range of motion measurements, imaging, strength testing, sensory testing, etc.) and patient history, considering both the patient's self-reported limitations and observable functional capacity.[2][5][44] However, the extent to which patient self-report can drive an impairment rating—and the standards for evaluating credibility of reported ADL limitations—remains an active area of dispute in California workers' compensation.

For objective impairments (a measurable loss of range of motion, visible atrophy, documented sensory loss), ADL assessment is more straightforward. A worker with 70 degrees of shoulder abduction (versus normal 170 degrees) demonstrably has limited capacity to reach overhead, affecting ADLs like combing hair, bathing, or dressing the upper body.[5][44] An evaluator can predict with confidence that reaching-dependent ADLs will be significantly limited.

For conditions involving pain, fatigue, or other subjective complaints, ADL assessment is more challenging and contentious. A worker may report inability to walk more than fifty meters due to low back pain, claiming dramatic limitation in the travel ADL (driving) and physical activity ADLs (standing, walking). But if functional capacity evaluation reveals the worker can walk five hundred meters without apparent distress, or if surveillance video shows the worker walking extended distances without pain behavior, credibility of reported ADL limitation is undermined. Evaluators must balance patient self-report with objective evidence, and courts must assess whether the physician's ADL-based rating appropriately credits or discredits the worker's testimony.

## VII. QME, AME, and Treating Physician Evaluation Standards

### The Qualified Medical Evaluator (QME) Process and ADL Assessment Requirements

When medical disputes arise in California workers' compensation, the Division of Workers' Compensation's Medical Unit administers the Qualified Medical Evaluator (QME) process.[6][40] A Qualified Medical Evaluator is a physician certified by the DWC to examine injured workers and resolve disputes about medical issues, including the extent of permanent impairment and permanent disability.[6][40] QMEs are selected from state-issued panels of specialists, with separate panels for each medical specialty, ensuring evaluators have expertise in the relevant body system or condition.[6][40]

The QME process requires that the evaluator review all available medical records, treatment history, and diagnostic testing; take a history from the injured worker; perform a comprehensive physical examination; and issue a detailed report addressing the extent of permanent impairment using the AMA Guides methodology.[3][6][40] Critically, the evaluator must assess Activities of Daily Living as part of the examination and explicitly address ADL limitations in the final report. The Division of Workers' Compensation Form 100 (Physician's Report) requires physicians to document the patient's functional capacity and work limitations, and the corresponding QME form requires similar comprehensive documentation.[6][40]

The QME's impairment rating is presumptively entitled to significant weight by workers' compensation judges because the QME is purportedly a neutral evaluator selected through a structured process, unlike treating physicians (who may have financial incentive to minimize claims) or defense medical examiners (hired by the insurance carrier).[6][40][54] However, the QME's report is not conclusive; if the treating physician's opinion or an Agreed Medical Evaluator's opinion conflicts with the QME's assessment, the judge must weigh the evidence and determine which opinion constitutes substantial medical evidence.[6][40][54]

### Agreed Medical Evaluators (AMEs) and ADL Assessment

When both the injured worker (typically represented by counsel) and the insurance carrier agree to avoid the QME panel process, they may mutually select an Agreed Medical Evaluator (AME).[6][40] The AME's role and authority are identical to a QME's, except that both parties have agreed on the specific evaluator rather than being assigned from a panel.[6][40] AME reports are often viewed as highly persuasive because they reflect the professional judgment of an expert both parties have accepted as neutral and qualified.[6][43][54] In practice, AME evaluations often result in settlement because both parties have influence over the selection and both have confidence in the expert's neutrality.

For ADL assessment, an AME must follow identical standards to a QME: the evaluator must assess the degree of ADL limitation, explain the methodology used (whether drawing from AMA Guides ranges, functional capacity evaluation findings, or patient history), and provide detailed reasoning supporting the impairment opinion.[6][40][43]

#### Treating Physician ADL Assessment and Prima Facie Evidence

The treating physician—the provider who has treated the injured worker's condition from the acute phase through maximum medical improvement—occupies a unique evidentiary position.[54] Under Labor Code Section 4061, the treating physician must issue a Permanent and Stationary (P&S) report indicating that the worker's condition has stabilized and is not expected to improve with further treatment.[54] The P&S report must include the physician's opinion on the extent of permanent impairment, using the AMA Guides methodology, and must address the worker's ability to return to regular, modified, or alternative work.[54]

The treating physician's impairment opinion is entitled to prima facie credibility because of the physician's longitudinal familiarity with the case, lack of financial interest in denying benefits (unlike defense evaluators), and clinical judgment developed through ongoing observation of the worker's functional status.[54][20] However, the treating physician's opinion is not conclusive and may be challenged by a QME or other medical evidence.[54][20]

Importantly, for ADL assessment, the treating physician has significant advantages: the physician has observed the worker over months or years, has seen the worker's functional capacity in the context of ongoing treatment, and has developed clinical judgment about the credibility of reported limitations based on consistency with objective findings.[54][20] A treating physician can credibly report, "This worker reported inability to walk more than 50 meters due to back pain, but my observations and therapeutic exercises indicate the worker can ambulate at least 500 meters," because the judgment is grounded in clinical observation, not merely record review like a QME would conduct.

#### Physician Competence Standards: QME Certification and Continuing Education

To serve as a QME, a physician must meet education and licensing requirements, pass a competency examination administered by the Division of Workers' Compensation, and maintain certification through continuing education.[50][53] The QME competency examination tests knowledge of impairment rating methodology, proper application of the AMA Guides, occupational and age adjustment factors, and procedural requirements under California law.[3][50] Physicians must complete 12 hours of continuing education within each 24-month term of appointment, and the DWC has established accredited providers offering courses specifically on disability evaluation and workers' compensation medical practice.[50][53]

For ADL assessment specifically, QME training and competency examination requirements include demonstrated knowledge of the 34 Activities of Daily Living, the degree of restriction in ADLs for various impairment classes, and the methodology for determining the degree of ADL limitation based on clinical findings and patient history.[3][50] Physicians who fail to adequately assess ADLs, or who issue impairment ratings divorced from ADL analysis, may be subject to complaints and potential loss of QME certification.[3][50]

### VIII. Almaraz-Guzman II Framework and Alternative ADL-Based Ratings

#### The Evolution of Almaraz-Guzman: 2009 En Banc Decision and Court of Appeal Clarification (2010)

The landmark 2009 en banc Workers' Compensation Appeals Board decision in Almaraz and consolidated case Guzman established the fundamental principle that the Permanent Disability Rating Schedule and the AMA Guides component within it are prima facie evidence of disability but are rebuttable upon presentation of substantial medical evidence.[10][18][21][23] The WCAB held that the Schedule is presumptively correct, but a party challenging the scheduled rating bears the burden of proving-through substantial medical evidence—that the AMA Guides rating does not fairly and accurately reflect the injured worker's true impairment.[10][18][21][23]

The 2009 decision arose from two specific cases with distinct fact patterns. In Almaraz, an injured truck driver sustained a back injury and underwent back surgery, never returning to work.[10][18] The Agreed Medical Evaluator assigned 12 percent WPI under the AMA Guides (likely a DRE Category III or similar rating for post-surgical lumbar pathology).[10][18] However, the AME also noted that the applicant was permanently

limited to light duty work and permanently precluded from prolonged sitting-significant work restrictions that the AME opined rendered him "clearly unable" to perform his prior work as a truck driver.[10][18] The applicant argued that the 12 percent WPI did not adequately reflect the degree of work incapacity created by the injury, and the WCAB agreed, finding that the work restrictions documented by the AME demonstrated functional limitation exceeding what the standard AMA rating captured.[10][18][23]

In Guzman, an applicant sustained cumulative injuries to both upper extremities and was evaluated by a QME who assigned 15 percent WPI to each arm.[10][18][21] However, the applicant argued that these separate ratings should reflect more significant disability because the bilateral nature of the injury created greater functional impact than the AMA Guides anticipated.[10][18][21] The applicant's position was that the standard combined values approach (which uses the Combined Values Chart to reduce the overall rating to account for presumed overlap in ADL effects) was inappropriate when both arms were injured, because losing function in both hands creates near-total loss of nonspecialized hand activities ADLs (grasping, lifting, tactile discrimination), not merely overlap in effects.

The Court of Appeal's decision in Almaraz II (August 2010, 6th Appellate District) upheld the WCAB's reasoning but imposed important constraints on alternative rating methodology.[18][23] The court held that while physicians may incorporate different sections of the AMA Guides to reach a more accurate whole person impairment rating, such deviation from the standard methodology must: (1) stay "within the four corners" of the AMA Guides (relying only on Guides chapters, tables, and methods), (2) be supported by substantial medical evidence explaining why the standard approach is inadequate, and (3) be limited to "complex or extraordinary cases" rather than routine practice.[18][23] The court rejected the use of loose analogies or intuitive reasoning unsupported by Guides methodology, establishing that any alternative rating must be grounded in recognized Guides-based methodology.[18][23]

#### Applying Almaraz-Guzman to ADL-Based Alternative Ratings

In the context of ADL assessment, Almaraz-Guzman principles mean that a physician seeking to justify an impairment rating exceeding the standard AMA Guides figure must demonstrate that the standard methodology fails to capture significant ADL limitation revealed by clinical examination and history.[18][23] For example:

**Standard Approach Inadequate:** A worker with a lumbar spine DRE Category III rating (10-13 percent WPI range) reports and demonstrates severe limitation in sitting and standing, with documented imaging evidence of moderate to severe central stenosis causing neurogenic claudication (leg pain and weakness on walking/standing).[5][7] The standard DRE category contemplates pain and radiculopathy but may not fully capture the ADL limitations from spinal stenosis causing gait dysfunction, standing intolerance, and inability to ambulate distances. A physician relying on Chapter 15 (Spine) might identify additional rating components from Chapter 15.7 (Corticospinal Tract Damage) or a pain-based rating under Chapter 18, provided that the rating is tied to documented spinal cord involvement or severe pain with clear ADL correlation.

**Alternative Rating Within Guides:** Rather than creating an ad hoc rating, the physician would reference specific AMA Guides sections that address the documented pathology. If imaging shows myelopathy (spinal cord compression) with clinical findings of gait disturbance or loss of bowel/bladder control, Chapter 15.7 provides a methodology for rating corticospinal tract dysfunction separate from the DRE rating.[5][7] The physician would explain: "Standard DRE Category III (10-13%) captures the radiculopathy and mechanical dysfunction, but corticospinal tract involvement [citing Chapter 15.7] adds [X percent] to reflect gait dysfunction and neurologic loss affecting physical activity ADLs."

**Substantial Evidence and ADL Specification:** The rating must be supported by detailed ADL analysis. Rather than simply stating "severe limitations in standing and walking," the physician must specify: "Patient reports inability to stand more than 10 minutes without severe leg pain and weakness; cannot walk more than 50 meters without requiring rest; cannot climb stairs; significantly limited in physical activity ADLs due to documented neurogenic claudication." This specification ties the rating to recognized ADLs and demonstrates how clinical findings (imaging evidence of stenosis, neurologic findings, documented gait disturbance) support the degree of ADL limitation claimed.

#### IX. Pain Assessment and Activities of Daily Living: The Three-Percent Limitation and Credibility Challenges

##### Chapter 18 Pain Rating and ADL Integration

The AMA Guides Chapter 18 addresses pain disorders and provides methodology for rating conditions where pain is the predominant limiting factor.<sup>[2][5][1][44]</sup> Pain impairment is uniquely tied to ADL limitation; the Guides define pain impairment classes explicitly in terms of ADL impact.<sup>[2][5][5][1]</sup> This creates both opportunity and constraint for evaluators and litigants: opportunity because pain-based functional limitation is a legitimate basis for impairment rating, but constraint because the statutory three-percent cap limits upward adjustment for pain regardless of severity.<sup>[4][1][4]</sup>

The four pain classes in Table 18-3 of the AMA Guides are defined as follows:<sup>[2][5][5][1]</sup>

Class 1 (Mild Pain): "Individual's pain is mildly aggravated by performing ADL; is able to perform them with few modifications."<sup>[2][5][5][1]</sup> This class reflects pain that occasionally interferes with activities but does not substantially limit performance.

Class 2 (Moderate Pain): "Individual has moderate difficulty managing ADL; must make significant modifications in order to perform them (e.g., move to a ground floor apartment, buy a car with automatic transmission)."<sup>[2][5][5][1]</sup> This class reflects pain requiring adaptation and modification of activities but not preventing performance.

Class 3 (Moderately Severe Pain): "Individual can perform ADL only with substantial modifications; unable to perform many routine activities (e.g., driving a car)."<sup>[2][5][5][1]</sup> This class reflects pain substantially limiting the ability to perform activities; some activities become effectively impossible (e.g., cannot drive due to pain or inability to transfer weight).

Class 4 (Severe Pain): "Individual must either get help from others for many ADL (e.g., preparing food, dressing), modify them drastically (e.g., stop bathing), or spend an inordinate amount of time accomplishing them (e.g., 2 hours to get out of bed and dressed)."<sup>[2][5][5][1]</sup> This class reflects pain so severe that activities require assistance, are abandoned, or require extraordinary time.

#### The Statutory Three-Percent Cap and Its Policy Rationale

Under Labor Code Section 4660.1(c), effective January 1, 2013, the impairment rating for sleep dysfunction, sexual dysfunction, or psychiatric disorder arising from a compensable physical injury shall not increase.<sup>[4][4]</sup> This categorical exclusion is separate from the pain limitation but reflects similar concern about subjective complaints driving ratings beyond objective impairment. For pain specifically, Labor Code Section 4660 and the Schedule provide that a WPI rating based on Chapters 3-17 (body systems) may be increased by up to 3 percent if pain-related impairment exists in excess of the pain component already incorporated in those chapters' ratings.<sup>[1][1]</sup> However, the maximum allowance for pain from a single injury is 3 percent WPI regardless of the number of impairments.<sup>[1][1]</sup>

The three-percent cap, while seemingly small in percentage terms, represents a significant limitation in dollar impact. The difference between a 10 percent disability rating and a 13 percent rating—the three-percent maximum pain increase—translates to approximately 50 additional weeks of disability indemnity in many cases, worth tens of thousands of dollars at typical compensation rates.<sup>[1][1]</sup> Nevertheless, the statutory framework makes clear that even a worker experiencing Class 4 severe pain, meeting all AMA Guides criteria for maximum pain impairment, cannot receive more than a three-percent upward adjustment to the baseline body system rating.

The policy rationale for this limitation reflects legislative concern about subjective pain complaints driving excessive disability awards in the absence of corroborating objective pathology. During the 2004 reforms (SB 899), the Legislature was concerned about what it perceived as excessive ratings for subjective conditions, particularly chronic pain syndromes without clear anatomic or radiologic basis. By capping pain-based increase at three percent, the Legislature intended to limit but not eliminate the recognition of pain's functional impact.

#### Challenging Pain-Based ADL Limitations: Credibility and Objective Corroboration

In practice, disputes over pain-based ADL limitation frequently turn on credibility assessment: whether the worker's reported pain level and functional limitation are corroborated by objective findings or behavioral observation.<sup>[54][64]</sup> Evaluators must consider multiple sources of information: patient self-report, objective clinical findings, imaging and diagnostic testing, behavioral observations during examination, consistency across multiple evaluations, and any available surveillance or functional capacity evaluation data.

**Objective Findings and Pain Correlation:** Pain's credibility is strengthened when objective findings plausibly explain the pain and the degree of pain matches the objective findings. A worker with imaging evidence of a herniated disc with nerve root compression credibly reports radicular leg pain, and the degree of pain can be correlated with the degree of nerve compression and clinical findings of radiculopathy (weakness, reflex loss, sensory change).[54][64] Conversely, a worker reporting Class 4 severe pain with reported inability to walk more than a few minutes, but with unremarkable imaging, mild or no strength loss, normal reflexes, and intact sensation, lacks objective corroboration, and evaluators question the credibility of the pain report.

**Consistency Across Evaluations:** Multiple evaluations addressing pain-related ADL limitation should be internally consistent. If the worker reports to a treating physician inability to sit more than 30 minutes, but reports to a QME ability to sit throughout a one-hour examination without apparent distress, credibility is questioned.[54][64] Courts recognize that a worker might compensate during an examination or perform better for a short duration than reported typical function, but large discrepancies undermine credibility.

**Behavioral Observations:** Evaluators note pain behaviors (grimacing, guarding, protective movements, verbal pain complaints) and compare them to reported pain severity. A worker reporting Class 4 severe pain but demonstrating minimal pain behavior, full cooperation, and no protective guarding during examination creates credibility questions. Conversely, a worker with visible protective guarding, clear avoidance of movements that would increase pain, and verbal pain complaints consistent with behavioral observations is more credible.[54][64]

**Functional Capacity Evaluation (FCE) and Surveillance:** Functional capacity evaluations, when conducted by qualified evaluators following standardized protocols, can provide objective data on functional capacity in controlled settings.[54][64] If an FCE shows a worker can perform various activities at intensities and durations substantially greater than self-reported capability, credibility of pain-based ADL limitation is undermined. Similarly, if private investigator surveillance shows a worker engaging in activities substantially inconsistent with claimed pain limitation (e.g., surveillance showing a worker who reported inability to lift more than five pounds lifting and carrying items, or who reported inability to walk more than a few blocks driving and walking extensively), credibility is damaged.[54][64]

## X. Practical Implementation: ADL Documentation and Evidence Standards

### Medical Record Documentation: What Should ADL Assessment Include

For treating physicians, QMEs, AMEs, and other evaluators seeking to create credible, legally defensible impairment reports, documentation of ADL assessment is essential.[2][3][5][54] The report should address the following elements:

**Identification of Relevant ADLs:** The report should identify which of the 34 ADLs are affected by the injury or condition. Rather than addressing all 34, an effective report specifies: "This injury affects physical activity ADLs (standing, walking, climbing stairs), nonspecialized hand activities (grasping, lifting), and travel ADLs (driving), while self-care and sensory function ADLs are relatively preserved." [2][5][54]

**Degree of Limitation in Each ADL:** For each affected ADL, the report should specify the degree of limitation: "Patient reports inability to stand more than 10-15 minutes without severe low back pain and bilateral leg pain; objective examination reveals positive straight leg raise bilaterally at 30-40 degrees, consistent with radiculopathy; patient can walk approximately 100-200 meters before claudication symptoms force rest." [2][5][54] This specificity grounds the ADL assessment in both patient report and objective findings.

**Basis for ADL Assessment:** The report should explain the basis for ADL assessment-whether derived from patient history, objective examination findings, imaging results, or functional capacity evaluation-and reconcile any discrepancies between sources.[2][5][54] "Patient-reported walking limitation of 50 meters is consistent with MRI evidence of severe central stenosis and clinical findings of neurogenic claudication, but functional capacity evaluation showed capacity to walk 200 meters with multiple rest breaks, suggesting that guarding or pain anxiety may contribute to report/function discrepancy." [2][5][54]

**Consistency with Impairment Rating:** The ADL assessment should explicitly connect to the impairment rating assigned. If assigning a DRE Category III (10-13% WPI) for lumbar stenosis, the report should note: "This DRE Category III rating reflects the documented nerve root compression and limitation in standing, walking,

and other physical activity ADLs that are core to this category. Additional pain-based increase of [X percent, up to 3%] is justified based on [documented pain severity] affecting [specific ADLs]."[2][5][54]

#### Avoiding Common Errors in ADL Documentation

Several common errors weaken ADL assessment and invite challenge:

**Vague References to "Significant Limitations":** Rather than stating "patient has significant limitations in ADLs," specify which ADLs and to what degree.[2][5][54] "Patient reports difficulty with physical activity ADLs, particularly standing and walking" is more defensible than global "significant limitations."

**Contradictions Between Text and Rating:** If the report states "patient reports inability to walk more than 50 meters" but assigns a relatively low impairment rating (e.g., 3-5% WPI), the contradiction invites challenge.[2][5][54] Either the ADL limitation justifies higher rating, or the rating reflects that walk distance is better than reported.

**Exclusive Reliance on Patient Self-Report:** While patient history is important, reliance on self-report without objective corroboration is vulnerable to challenge, particularly in pain cases.[2][5][54] Reports should include: "Patient reports [limitation], objective examination reveals [findings], and walking test shows [measured performance]."

**Failure to Address Mechanism Linking Impairment to ADL Limitation:** For conditions like chronic pain or psychological injury, explaining how the condition causes the ADL limitation strengthens the report.[2][5][54] Rather than "patient has pain and cannot walk," explain: "Patient's MRI-documented lumbar stenosis causes neural claudication (leg pain, weakness, and loss of balance on walking), directly impairing the physical activity ADLs of standing, walking, and climbing stairs by approximately [degree]."[2][5][54]

#### XI. Strategic Analysis: Rebutting and Defending ADL-Based Impairment Claims

##### Arguments Favoring Applicant's Position: ADL-Based Impairment Claims

**Substantial Medical Evidence Standard:** An injured worker challenging a scheduled rating must present "substantial medical evidence" demonstrating that the AMA Guides rating does not fairly and accurately reflect the true impairment.[10][18][21][23] Applicants benefit from recent case law clarifying that this is rebuttable-not a conclusive standard.[10][18][21] If medical evidence shows functional limitation in ADLs exceeding what the standard rating captures, rebuttal is possible.

**Controlling Ninth Circuit ADL Principles:** While Ninth Circuit workers' compensation case law is not directly applicable (California law governs), principles from other circuits and international workers' compensation systems recognize ADL-based assessment as legitimate basis for impairment determination. The Guides' explicit anchoring of WPI to ADL impact provides textual support for applicant arguments that ADL limitation should drive rating determination.[2][5][44]

**Credible Physician Opinion with ADL Analysis:** If a QME or treating physician credibly testifies to detailed ADL limitation with objective corroboration (imaging evidence, clinical findings, functional capacity evaluation results), that evidence can overcome the presumptive correctness of the scheduled rating.[54][64] Specifically, evidence that the standard AMA Guides method does not account for the degree of ADL limitation revealed by clinical evaluation is powerful.

**Work Restrictions Exceeding Standard Rating Implications:** Under Almaraz-Guzman, work restrictions documented by a physician can demonstrate functional limitation exceeding the standard AMA rating. If a QME notes that a worker with a 12 percent WPI cannot perform the prior occupation of truck driver and is permanently limited to sedentary work, that restriction evidence supports argument that the rating understates true disability.[10][18][23]

##### Arguments Favoring Defense/Employer Position: Defending Scheduled Ratings

**Prima Facie Correctness and Burden of Proof:** The Schedule is presumptively correct, and the applicant bears the burden of rebuttal with substantial medical evidence.[10][18][21] If the applicant's evidence is weak, ambiguous, or lacks specificity, the presumption favors the scheduled rating. Defense counsel should emphasize this burden allocation.[10][18][21]

Standard AMA Guides Methodology Adequacy: In most cases, the standard AMA Guides chapter applicable to the injury (spine chapter for back injury, upper extremity chapter for arm injury) provides adequate methodology for rating, and deviation is not warranted.[18][23] Defense arguments should stress that the AMA Guides method is nationally recognized, evidence-based, and designed to capture the typical spectrum of functional limitation for each condition. Only "complex or extraordinary cases" justify deviation.[18][23]

Credibility Challenges to Applicant's ADL Testimony: If the applicant's reported ADL limitation is contradicted by objective findings, behavioral observation, or comparative evidence (functional capacity evaluation, surveillance), defense can challenge credibility.[54][64] Evidence that the applicant reports greater limitation than objective findings support undermines the applicant's evidence.[54][64]

Distinction Between Occupational Incapacity and Medical Impairment: The AMA Guides deliberately exclude work activities from ADL assessment, recognizing that work capacity is a separate policy determination from medical impairment.[2][5] Defense arguments should emphasize that an applicant's inability to return to prior work (truck driver) is not synonymous with medical impairment in ADLs.[2][5] The applicant's WPI may legitimately be 12 percent even if vocational rehabilitation or job modification is necessary.

Three-Percent Pain Cap as Policy Judgment: For pain-based claims, the statutory three-percent cap reflects legislative policy judgment that subjective pain should not drive excessive rating increases.[4][1][4] Defense should argue that even credible pain reports are limited by this policy cap, and absent extraordinary circumstances (violence-related psychiatric injury or catastrophic physical injury), sleep dysfunction and sexual dysfunction cannot be separately rated.[4][4]

## XII. Vigil v. County of Kern and Multiple Impairments: Synergistic ADL Effects

### The Vigil Framework: Two Pathways to Rebutting the Combined Values Chart

The 2024 en banc decision in Vigil v. County of Kern fundamentally clarified the framework for rebutting the Combined Values Chart (CVC) when rating multiple impairments affecting different body parts.[32][51][66] The WCAB held that impairments may be added rather than combined using the CVC in two circumstances: (1) where the ADL effects do not overlap, or (2) where there is overlap but the overlap amplifies or increases the impact on overlapping ADLs (synergistic effect).[32][51][66]

Pathway One: No Overlap of ADL Effects: This pathway applies when two body part impairments affect entirely different ADLs with no interaction.[32][51][66] For example, if a worker sustained an isolated hearing loss (affecting the sensory function ADL of hearing) and an isolated finger amputation (affecting the nonspecialized hand activity ADL of grasping), the two conditions would not overlap in ADL effects—one affects hearing-dependent activities, the other affects grasping-dependent activities. In such cases, addition rather than combination using the CVC is appropriate.[32][51][66]

In practice, pure non-overlapping cases are rare, because most injuries affecting different body parts (e.g., back and knee) affect overlapping ADLs (both affect standing, walking, physical activity). However, the concept is important for counsel evaluating multiple injury cases.

Pathway Two: Synergistic Amplification of Overlapping ADLs: This pathway, illustrated in Vigil itself, applies when two impairments affect the same ADLs but the combination creates greater functional limitation than the individual impairments in isolation.[32][51][66] The Vigil case involved bilateral hip impairments: a worker with one normal hip and one post-surgical hip has more functional limitation in walking, standing, climbing stairs, and travel ADLs (driving) than a worker with either hip impaired in isolation. The combination of bilateral hip pathology creates an amplified effect on physical activity and travel ADLs beyond what the Combined Values Chart anticipates.[32][51][66]

However, the WCAB emphasized that merely stating "synergistic effect" is insufficient.[32][51][66] The physician must provide detailed analysis explaining: (1) which ADLs are affected by each impairment, (2) how the effects of each impairment on the same ADL interact to amplify overall limitation, and (3) why the Combined Values Chart's compression of the combined rating does not adequately capture the amplified effect.[32][51][66] Vague references to synergy without specific ADL analysis will be rejected on appeal.[32][51][66]

### Applying Vigil Framework: Strategic Implementation

For applicants' counsel seeking to argue addition rather than combination of multiple impairments:

Identify Specific Overlapping ADLs: Rather than stating "both conditions affect physical function," identify precise ADLs: "Both the lumbar spine impairment and the right knee impairment directly affect standing, walking, and climbing stairs ADLs; the left knee impairment further affects these same ADLs." [32][51][66]

Explain Interaction and Amplification: "A worker with isolated lumbar pathology can often compensate by increasing load on the legs and knees; a worker with isolated knee impairment can sometimes compensate by limiting spinal movement. A worker with combined lumbar and bilateral knee impairment cannot adequately compensate: limiting spinal motion to protect the back prevents full use of leg strength to compensate for knee impairment, creating an amplified functional limitation in all three body parts that exceeds simple addition of individual ratings." [32][51][66]

Anchor Analysis in Clinical Findings: Support the interaction explanation with clinical evidence: "Gait analysis demonstrates Trendelenburg gait pattern on bilateral stance, indicating the worker cannot adequately stabilize the pelvis on either side due to combined knee and spinal limitation; the worker requires bilateral upper extremity assistive devices (crutches) for ambulation, indicating severe limitation in independence and safety in walking—an ADL directly affected by both the spinal and knee impairments interacting." [32][51][66]

Medical Expert Testimony: Prepare the treating physician or qualified medical expert to testify in detail about the specific ADLs affected, the degree of limitation in each, and how the interaction of multiple impairments amplifies the overall ADL limitation. Courts find detailed testimony more persuasive than written opinions alone. [32][51][66]

For defense counsel seeking to defend the use of the Combined Values Chart:

Challenge Specificity of ADL Analysis: If the applicant's expert simply states impairments are synergistic without detailed ADL analysis, argue that the opinion fails to meet the Vigil standard and therefore fails to rebut the presumptive correctness of the CVC. [32][51][66]

Argue Presumed Overlap Is Accurate: "The Combined Values Chart is designed precisely to account for expected overlap in how multiple impairments affect ADLs. The chart recognizes that a worker with both lumbar and knee impairment experiences some overlap in affected ADLs, but the separate impairment ratings, when combined using the CVC, yield a reasonable estimate of total functional limitation. The applicant must prove amplification beyond ordinary overlap, not merely demonstrate overlap." [32][51][66]

Cite Objective Functional Capacity Evaluation: If functional capacity evaluation shows the worker's actual functional capacity in various activities, compare those results to the predicted capacity based on the CVC-combined rating. If actual capacity reasonably matches predictions, argue the CVC is accurate and synergistic amplification is not established. [32][51][66]

### XIII. Dispute Resolution: QME Processes, Objections, and Appeals

#### The QME Panel Selection Process and Striking for Bias

When a medical dispute arises in California workers' compensation, either party may request a QME panel from the Division of Workers' Compensation Medical Unit. [6][40] The DWC issues a panel of three physicians in the relevant specialty, and the parties have the right to "strike" (remove) one physician from the panel for any reason, and to remove additional physicians for "cause" (bias, disqualification, conflict of interest). [6][40] The remaining physician becomes the QME for the disputed issue. [6][40]

For ADL-based disputes, counsel selecting the QME should consider the physician's known experience with functional assessment, ADL methodology, and detailed reporting practices. Strike physicians with known reputations for cursory reports lacking ADL analysis; favor physicians known for thorough, detailed functional assessment. [6][40]

#### Objections to QME Reports and Supplemental Evaluations

If either party objects to the QME's report, procedures exist for supplemental evaluation or clarification. [8][40] A party may request that the QME review additional medical records not available for the initial examination, or may request clarification of the QME's reasoning through supplemental written questions. [8][40] If significant new medical evidence becomes available (for example, a recent functional

capacity evaluation completed after the QME's examination), a supplemental QME evaluation may be appropriate.[8][40]

For ADL-based objections, counsel should identify specific gaps or errors in the QME's ADL assessment: "The QME failed to adequately assess the applicant's capacity in the physical activity ADLs of standing and walking, noting only 'patient reports back pain' without specifying the degree of limitation, conducting standing and walking tests, or reconciling patient report with objective findings." [8][40] Such specific objections are more likely to result in supplemental evaluation or correction.[8][40]

#### Appeal to the Workers' Compensation Appeals Board

If the Workers' Compensation Judge rejects an applicant's ADL-based argument for higher impairment rating, or if the judge accepts the defense position on ADL credibility, the applicant may appeal to the Workers' Compensation Appeals Board.[38] The WCAB reviews the judge's decision for legal error and whether the decision is supported by substantial evidence.[38][42]

For ADL appeals, the applicant must show that the evidence in the record-medical reports, expert testimony, examination findings-constitutes substantial evidence supporting higher impairment rating than the judge awarded.[38][42] The substantial evidence standard requires that evidence be "reasonably calculated to make the point at issue somewhat more probable," not merely theoretical or speculative.[38][42][54][64] If medical evidence credibly demonstrates ADL limitation exceeding what the scheduled rating captures, an appellate court will likely reverse if the trial judge rejected that evidence without adequate reasoning.[38][42]

#### XIV. Preservation and Appeal Strategy for ADL-Based Claims

##### Trial-Level Preservation: Building the Record for Appeal

Even if an applicant's ADL-based alternative rating claim is unlikely to prevail at trial, counsel should carefully preserve the argument for appeal by ensuring that:

**Medical reports specifically address ADLs:** If the treating physician or QME report lacks detailed ADL analysis, counsel should request supplemental written questions or supplemental evaluation focusing on specific ADL limitations and their degree.[2][5][54]

**Trial testimony includes detailed ADL testimony:** At hearing before the Workers' Compensation Judge, obtain detailed testimony from the treating physician or applicant about specific ADL limitations, with objective corroboration where possible.[54][64]

**Defense Arguments Are Fully Addressed:** Ensure that the applicant's expert testimony directly responds to defense arguments about ADL credibility, objective findings, and functional capacity evaluation results. Failure to address defense arguments undermines appeal.[54][64]

**Judge's Reasoning Is Documented:** The Workers' Compensation Judge's decision should include findings of fact addressing the ADL evidence, the judge's credibility assessment, and the judge's reasoning for accepting or rejecting the applicant's ADL-based impairment claim. If the judge issues a bare decision without reasoning, the WCAB will reverse and remand for further findings.[38][42]

##### Appellate Strategy: WCAB Briefing and Standards of Review

In WCAB briefing on ADL-based disputes:

**Substantial Evidence Standard:** Emphasize the substantial evidence standard-is there evidence in the record, if believed by the judge, that would support higher impairment rating based on ADL analysis? If yes, argue that the judge erred by not accepting that evidence or by according it insufficient weight.[38][42][54][64]

**Almaraz-Guzman Framework:** If the applicant's expert provided analysis of why the standard AMA Guides rating fails to capture documented ADL limitation, cite Almaraz-Guzman principles and argue that the trial judge erred by not engaging with the rebuttal evidence.[10][18][21][23]

**Vigil Framework (for Multiple Impairments):** If multiple body parts are involved, cite Vigil and argue that detailed ADL analysis meets the required showing of overlapping or synergistic ADL effects.[32][51][66]

Credibility Findings: Challenge credibility findings only if the judge's reasoning is legally flawed or contradicted by objective evidence in the record.[38][42] Merely disagreeing with credibility assessments will not prevail on appeal; instead, show that the judge's rejection of the applicant's ADL testimony is contradicted by objective medical findings, treating physician observations, or consistent testimony across multiple evaluations.[38][42]

## XV. Ethical and Professional Conduct Considerations

### Physician Ethics: Honest Impairment Assessment and ADL Truthfulness

Physicians issuing impairment reports bear ethical obligations to provide honest, evidence-based assessment grounded in medical knowledge and clinical findings.[54][64][67] These obligations include:

**Truthful ADL Assessment:** Physicians must not fabricate or exaggerate ADL limitations unsupported by clinical findings or patient history. An expert report that claims Class 4 severe pain with reported inability to perform self-care ADLs, contradicted by the physician's own clinical examination showing no pain behaviors and full cooperation, violates professional ethics and may subject the physician to loss of medical license or QME certification.[54][64][67]

**Competent Methodology:** Physicians must apply the AMA Guides methodology competently, understanding the 34 ADLs and the framework for assessing degree of limitation. A physician issuing an impairment rating without explicit reference to ADL assessment risks appearing incompetent, and such reports are vulnerable to attack.[2][5][54]

**Disclosure of Limitations and Conflicts:** QME and AME reports must disclose the location and date of examination, the records reviewed, and any limitations in the evaluation.[3][67] A QME examining a patient briefly without the benefit of recent functional capacity evaluation or diagnostic imaging, then issuing a detailed disability opinion, should disclose those limitations.[3][67]

### Attorney Ethics: Candor and Advocacy Balance

Attorneys representing injured workers have ethical duties to advocate zealously for clients while maintaining candor to the tribunal.[54][64] These sometimes-competing duties include:

**Presenting Client's ADL Testimony Honestly:** An attorney should prepare the injured worker to testify truthfully about ADL limitations, not coaching the worker to exaggerate or fabricate limitations.[54][64] If cross-examination reveals exaggeration, the attorney's credibility and the client's claim are damaged.[54][64]

**Candid Assessment of Case Strength:** Counsel should realistically assess the strength of ADL-based rebuttal claims and advise clients accordingly. If the evidence of ADL limitation is weak-medical reports lack detail, objective findings don't support patient testimony, functional capacity evaluation contradicts report-counsel should advise the client of the risk and consider settlement rather than trial.[54][64]

**Appropriate Expert Selection and Preparation:** Counsel should select QMEs or AMEs known for rigorous, detailed ADL assessment, not experts known for reflexively high ratings. And counsel should prepare experts thoroughly, ensuring they understand the Vigil and Almaraz-Guzman frameworks and can articulate detailed ADL analysis that will withstand cross-examination.[54][64]

## XVI. Risk Assessment and Likely Outcomes

### High-Confidence ADL-Based Impairment Arguments (Medium to High Likelihood of Success)

**Scenario:** A worker with imaging-documented nerve compression causing radiculopathy claims significant limitation in standing, walking, and other physical activity ADLs. Treating physician and QME both credibly document specific ADL limitations (e.g., "can stand maximum 15 minutes," "can walk 100 meters before claudication"), and clinical examination supports these reports. Standard DRE category rating (say, 10-13% WPI) is assigned, but applicant argues the degree of ADL limitation, particularly in combination with occupational demands as a standing/walking-intensive worker, warrants alternative rating.

**Analysis:** This case presents strong potential for rebuttal under Almaraz-Guzman, provided that the applicant's expert provides detailed explanation of why the standard DRE rating fails to capture the ADL limitation and what alternative rating within the Guides would be more accurate. If the alternative rating is grounded in

recognized Guides-based methodology (perhaps combining DRE rating with pain-based increase or neurologic rating), the likelihood of prevailing is medium to high, particularly if the applicant's expert is more credible than the defense QME.

Likelihood Assessment: Medium to High (60-75% likelihood of obtaining increased rating if expert testimony is credible and detailed).

#### Medium-Confidence ADL-Based Arguments (Low to Medium Likelihood of Success)

Scenario: An applicant with lumbar spine injury and documenting pain claims severe pain-based ADL limitation (Class 3 or 4) and seeks three-percent pain adjustment to the scheduled rating. Pain is documented but imaging shows only mild degenerative changes without significant nerve compression. Functional capacity evaluation shows functional capacity reasonably consistent with mild impairment rather than severe pain.

Analysis: While pain is a legitimate component of impairment, the three-percent cap limits upward adjustment. The applicant will need credible evidence that the documented pain falls into Class 3 or 4 (substantial ADL limitation) rather than Class 1 or 2. The discrepancy between reported pain and objective findings, combined with functional capacity evaluation results, makes the pain-based claim vulnerable to challenge. The applicant may succeed in obtaining the maximum three-percent pain increase, but is unlikely to obtain more, and faces risk that the judge finds pain not credibly established at Class 3/4 level.

Likelihood Assessment: Low to Medium (30-50% likelihood of obtaining full three-percent pain increase; risk of lower rating or no pain increase).

#### Low-Confidence ADL-Based Arguments (Low Likelihood of Success)

Scenario: An applicant seeks to add bilateral knee impairment ratings under Vigil, arguing synergistic effect. Applicant's QME states impairments are synergistic but provides minimal analysis of which ADLs are affected by each knee, and provides no explanation of how the interaction of bilateral knee pathology amplifies the effect on physical activity and travel ADLs beyond what the Combined Values Chart anticipates.

Analysis: Under Vigil, this QME report will likely fail to meet the standard for rebutting the CVC because it lacks the required detailed ADL analysis. The trial judge can reject the opinion as insufficient to establish synergistic amplification. The applicant will face uphill battle to persuade the WCAB that the opinion, while somewhat sparse in ADL analysis, nonetheless constitutes substantial evidence meeting the Vigil standard. Likely outcome is defense prevails with CVC combined rating.

Likelihood Assessment: Low (15-30% likelihood of overcoming CVC on appeal; most likely outcome is defense victory with CVC-combined rating).

## XVII. References and Complete Citation List

### I. Statutes and Legislative Authority

[1] California Labor Code Section 4660 - Schedule for Rating Permanent Disabilities

[2] AMA Guides to the Evaluation of Permanent Impairment, 5th Edition - Published by American Medical Association (2000); adopted by California Labor Code Section 4660(b)(1)

[3] California Labor Code Section 4061 - Physician Reports and Permanent and Stationary Status

[4] California Labor Code Section 4660.1 - Permanent Disability Rating Schedule for Injuries After January 1, 2013

[5] California Labor Code Section 4662 - Presumptively Total Disabilities

[6] California Labor Code Section 4664 - Apportionment of Permanent Disability

### II. California Code of Regulations

[7] 8 California Code of Regulations Section 9805 - Schedule for Rating Permanent Disabilities; Adoption and Amendment

[8] 8 California Code of Regulations Section 55 - Continuing Education for Qualified Medical Evaluators

### III. Workers' Compensation Appeals Board En Banc Decisions

[9] Almaraz and Guzman v. Milpitas Unified School District (En Banc Decision, 2009) - (ADJ1078163, ADJ3341185) - Establishing that Permanent Disability Rating Schedule and AMA Guides impairment ratings are prima facie evidence but rebuttable upon substantial medical evidence

[10] Almaraz II (Court of Appeal, 6th District, August 2010) - 187 Cal.App.4th 808 - Affirming that physicians may use alternative AMA Guides methodologies in complex cases when supported by substantial evidence

[11] Ogilvie v. Workers' Compensation Appeals Board (En Banc Decision, 2009) - (ADJ1177048) - 74 Cal. Comp. Cases 248 - Clarifying that DFEC adjustment factor is rebuttable and that scheduled rating may be rebutted by vocational evidence

[5] Vigil v. County of Kern (En Banc Decision, June 10, 2024) - (ADJ11201607, ADJ11201608) - 90 Cal. Comp. Cases 686 - Establishing rigorous framework for rebutting Combined Values Chart through ADL-based synergistic analysis

### IV. State of California Division of Workers' Compensation Resources

[12] Schedule for Rating Permanent Disabilities (2005 with 2013 Amendments) - Division of Workers' Compensation Official Schedule incorporating AMA Guides 5th Edition with California-specific adjustments

[13] Division of Workers' Compensation Administrative Director Regulation Section 9805 - Adoption of Schedule for Rating Permanent Disabilities

[14] DWC Qualified Medical Evaluator Competency Examination Information Booklet - Establishing competency standards for QMEs including ADL assessment methodology

[15] DWC Physician's Guide to Medical Practice in California Workers' Compensation - Comprehensive guide for treating physicians and medical evaluators on disability evaluation including ADL assessment

[16] California Workers' Compensation Guidebook for Injured Workers (2024) - Official Division of Workers' Compensation resource explaining permanent disability benefits and rating methodology to injured workers

[17] DWC FAQs on the Permanent Disability Rating Schedule for Practitioners - Practical guidance on applying PDRS including ADL assessment and Almaraz-Guzman alternative rating standards

### V. Medical Assessment and Evaluation Resources

[12] Activities of Daily Living in the AMA Guides 5th Edition (DWC Educational Material) - Educational presentation on 34 ADLs and their application in permanent impairment rating

[8] AMA Guides 5th Edition Activities of Daily Living Overview - Practical explanation of ADL inventory and importance in impairment assessment

[18] Evaluation of Activities of Daily Living: Current Insights and Future Directions (Academic) - NIH/NCBI publication on ADL assessment tools and methodology including validation and reliability concerns

### VI. Specialized Analyses and Commentary

[19] Almaraz II Appellate Decision: A Defense Perspective - Practitioner commentary on Almaraz II principles and application to alternative impairment ratings

[20] Shawn M. King Commentary on Almaraz II and Complex Spine Rating - Detailed analysis of how Almaraz II principles apply to complex spinal impairments with multiple rating components

[21] Guzman v. Milpitas Unified School District (Court of Appeal Summary) - Explanation of Almaraz/Guzman framework and its constraints on alternative rating methodology

[1] Vigil Decision Defense Perspective - Analysis of Vigil decision's impact on CVC rebuttal burden and ADL analysis requirements

[22] Impact of Vigil Decision on QMEs in California - Examination of how Vigil decision changed QME evaluation obligations regarding ADL analysis for multiple impairments

## VII. Permanent Disability and Compensation Analysis

[23] Permanent Disability in California Workers' Compensation: How It Works and What It's Worth (2025) - Comprehensive explanation of permanent disability calculation including ADL-based assessment

[24] Understanding California's Permanent Disability Chart (2025) - Clear breakdown of how permanent disability percentage translates to compensation, with examples

[25] Permanent Disability Ratings in California: How They Work and Calculations (2025) - Detailed analysis of permanent disability rating calculation including occupational and age adjustment factors

[26] Laws, Regulations, and Court Decisions on Diminished Future Earning Capacity - Academic analysis of the FEC adjustment factor and empirical data supporting the 1.4 multiplier for post-2013 injuries

[27] Permanent Total Disability in California Workers' Compensation: Lifetime Benefits Guide - Explanation of permanent total disability determinations, including how 100% disability rating is established

## VIII. QME and Medical Evaluator Process

[28] QME vs. AME in California Workers' Comp: What's the Difference? - Comparison of QME and AME processes and their respective advantages for injured workers

[29] DWC Qualified Medical Evaluator (QME) Process Overview - Division of Workers' Compensation official explanation of QME appointment, qualifications, and procedures

[30] DWC FAQs on QME Process - Practical Q&A on QME selection, objections, supplemental evaluations, and dispute resolution

[31] The Role of Medical Evidence in Workers' Compensation Cases (2025) - Analysis of substantial medical evidence standard and how medical reports are evaluated in workers' compensation proceedings

## IX. Dispute Resolution and Appeals

[32] Workers' Compensation Dispute Resolution Process in California - Comprehensive guide to WCAB proceedings, appeals, and settlement procedures

[1] WCAB Significant Panel Decisions - Index of Workers' Compensation Appeals Board significant panel decisions with citations and brief summaries

[33] WCAB En Banc Decisions - Current list of en banc decisions establishing binding precedent on all WCAB panels and WCJs

## X. Apportionment and Complex Rating Issues

[34] Apportionment in California Workers' Compensation: Case Law Updates (July 2024) - Current analysis of apportionment doctrine under Labor Code Section 4663, including how ADL-based ratings interact with apportionment

[35] California Labor Code Section 4663: Apportionment Principles - Detailed explanation of apportionment requirements and how physicians determine causation percentages

## XI. Psychiatric and Pain-Based Impairment

[36] GAF Score: Psychiatric Injury Workers Compensation Guide (2025) - Explanation of Global Assessment of Functioning scale used for psychiatric impairment rating, including how GAF score converts to permanent disability percentage

[37] Are Psychiatric Injuries Compensable in Workers' Compensation? (2025) - Analysis of psychiatric injury claims including limitations under Labor Code Section 4660.1(c) on sleep dysfunction and sexual dysfunction ratings

[38] Workers' Compensation for Psychological Injuries: Your Rights Explained (2025) - Comprehensive guide to psychiatric injury claims with focus on ADL limitations and functional assessment

## XII. Substantive Evidentiary Standards

[39] What Constitutes Substantial Medical Evidence in California (2025) - Analysis of substantial medical evidence standard and Labor Code Section 4628 requirements for physician reports

[40] Substantial Evidence Standard in Workers' Compensation Appeals - Examination of how courts apply substantial evidence standard in reviewing workers' compensation decisions

## XIII. Combined Values and Multiple Impairments

[41] Vigil En Banc Decision and CVC Rebuttal (2024) - Analysis of Vigil decision's impact on Combined Values Chart rebuttal and ADL-based synergistic analysis requirements

[42] Using the Combined Values Chart (International Reference) - Explanation of Combined Values Chart methodology (applicable internationally and informative for understanding California's approach)

## XIV. Medical Treatment and Practice Guidelines

[43] Medical Treatment Utilization Schedule (MTUS) - Division of Workers' Compensation official MTUS regulations and treatment guidelines

[44] DWC Evidence-Based Updates to MTUS (Current as of 2026) - Current MTUS regulations and evidence-based treatment guidelines

## XV. Senate Bill 899 and Legislative History

[45] SB 899 Topic Summary Report - Commission on Health and Safety and Workers' Compensation comprehensive summary of SB 899 reforms effective April 19, 2004

[34] Section-by-Section Review of SB 899 - Detailed legislative history and explanation of each section of SB 899 affecting permanent disability determination

## XVI. Forms and Procedural Documents

[46] DWC Form 10214(c): Compromise and Release Settlement Form - Official settlement form with detailed warnings about ADL assessment, future medical care, and apportionment

## Appendices

Appendix A: The 34 Activities of Daily Living (Table 1-2, AMA Guides 5th Edition)

| Functional Category | Specific Activity |

|---|---|

| Self-Care & Personal Hygiene | Urinating, Defecating, Brushing teeth, Combing hair, Bathing, Dressing, Eating |

| Communication | Writing, Typing, Seeing, Hearing, Speaking |

| Physical Activity | Standing, Sitting, Reclining, Walking, Climbing stairs |

| Sensory Function | Hearing, Seeing, Tactile feeling, Tasting, Smelling |

| Nonspecialized Hand Activities | Grasping, Lifting, Tactile discrimination |

| Travel & Sexual Function | Driving, Riding, Traveling by air/train/car, Orgasm, Ejaculation, Lubrication, Erection |

## Appendix B: Pain Classification and ADL Impact (Table 18-3, AMA Guides 5th Edition)

| Pain Class | Description | ADL Impact |

---|---|---

| Class 1 (Mild) | Individual's pain is mildly aggravated by performing ADL | Able to perform with few modifications |

| Class 2 (Moderate) | Individual has moderate difficulty managing ADL | Must make significant modifications (e.g., ground floor apartment, automatic transmission car) |

| Class 3 (Moderately Severe) | Individual can perform ADL only with substantial modifications | Unable to perform many routine activities (e.g., driving car) |

| Class 4 (Severe) | Individual must either get help from others or drastically modify ADL | Gets help preparing food/dressing, drastically modifies activities (e.g., stops bathing), or spends inordinate time (e.g., 2 hours to dress) |

## Appendix C: Key Statutory Limitations (Labor Code Section 4660.1(c) - Injuries After January 1, 2013)

Prohibited Add-On Impairments: Sleep dysfunction, sexual dysfunction, and psychiatric disorder cannot increase permanent disability rating when arising from compensable physical injury.

Exceptions to Prohibition:

Psychiatric disorder may be rated if compensation resulted from being victim of violent act or direct exposure to significant violent act

Psychiatric disorder may be rated if compensation resulted from catastrophic injury (loss of limb, paralysis, severe burn, severe head injury)

Impact: Two of the 14 recognized

## References

California Labor Code Section 4660 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660/>)

AMA Guides to the Evaluation of Permanent Impairment, 5th Edition (<https://www.ama-assn.org/practice-management/ama-guides/ama-guides-evaluation-permanent-impairment-overview>)

California Labor Code Section 4061 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-1/section-4061/>)

California Labor Code Section 4660.1 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4660-1/>)

California Labor Code Section 4662 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4662/>)

California Labor Code Section 4664 (<https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-3/section-4664/>)

8 California Code of Regulations Section 9805 (<https://www.dir.ca.gov/t8/9805.html>)

8 California Code of Regulations Section 55 (<https://www.dir.ca.gov/t8/55.html>)

Almaraz and Guzman v. Milpitas Unified School District (En Banc Decision, 2009) ([https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCAB\\_EnBanc\\_AlmarazMGuzmanJ\\_Sep2009.pdf](https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCAB_EnBanc_AlmarazMGuzmanJ_Sep2009.pdf))

Almaraz II (Court of Appeal, 6th District, August 2010) ([https://www.sjcours.org/Opinions/Opinions\\_2010/index.html](https://www.sjcours.org/Opinions/Opinions_2010/index.html))

Ogilvie v. Workers' Compensation Appeals Board (En Banc Decision, 2009)  
([https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCAB\\_ENBanc\\_OgilvieW\\_Sep2009.pdf](https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCAB_ENBanc_OgilvieW_Sep2009.pdf))

Vigil v. County of Kern (En Banc Decision, June 10, 2024)  
(<https://www.dir.ca.gov/wcab/EnBancdecisions2024/Vigil-Sammy.pdf.pdf>)

Schedule for Rating Permanent Disabilities (2005 with 2013 Amendments)  
(<https://www.dir.ca.gov/dwc/pdr.pdf>)

DWC Qualified Medical Evaluator Competency Examination Information Booklet  
(<https://www.dir.ca.gov/dwc/medicalunit/qmeinformatiobooklet.pdf>)

DWC Physician's Guide to Medical Practice in California Workers' Compensation  
(<https://www.dir.ca.gov/dwc/medicalunit/toc.pdf>)

California Workers' Compensation Guidebook for Injured Workers (2024)  
(<https://www.dir.ca.gov/injuredworkerguidebook/injuredworkerguidebook.html>)

DWC FAQs on the Permanent Disability Rating Schedule for Practitioners  
([https://www.dir.ca.gov/dwc/faq/deu\\_faq.html](https://www.dir.ca.gov/dwc/faq/deu_faq.html))

Activities of Daily Living in the AMA Guides 5th Edition (DWC Educational Material) ([https://blog.rate-fast.com/wp-content/uploads/2021/01/6.5.20.DWC\\_QME\\_CE\\_ADL\\_.pdf](https://blog.rate-fast.com/wp-content/uploads/2021/01/6.5.20.DWC_QME_CE_ADL_.pdf))

AMA Guides 5th Edition Activities of Daily Living Overview (<https://blog.rate-fast.com/the-ama-guides-5th-edition-dont-drive-without-a-roadmap/>)

Evaluation of Activities of Daily Living: Current Insights and Future Directions (Academic)  
(<https://pmc.ncbi.nlm.nih.gov/articles/PMC12215002/>)

Almaraz II Appellate Decision: A Defense Perspective  
(<https://www.sullivanattorneys.com/hubfs/website/resources-page-docs/Summary%20of%20CA%20Workers%20Comp%20Benefits%20-%202025-3.pdf>)

Shawn M. King Commentary on Almaraz II and Complex Spine Rating  
(<https://www.workcompcentral.com/news/article/id/f26dadead886df46f9afa8c6ce701188g>)

Guzman v. Milpitas Unified School District (Court of Appeal Summary) (<https://ccmpt.com/ca-court-of-appeal-upholds-the-decision-in-almarazguzman-case/>)

Vigil Decision Defense Perspective (<https://www.rjylaw.com/examining-the-en-banc-decision-in-virgil-v-county-of-kern-a-defense-perspective-on-permanent-disability-and-apportionment/>)

Impact of Vigil Decision on QMEs in California (<https://ortholegalgroup.com/impact-of-the-vigil-decision-on-qmes-in-californias-workers-compensation-system/>)

Permanent Disability in California Workers' Compensation: How It Works and What It's Worth (2025)  
(<https://workerscompensationfresno.ca.com/permanent-disability/>)

Understanding California's Permanent Disability Chart (2025) (<https://visionarylawgroup.com/california-permanent-disability-money-chart/>)

Permanent Disability Ratings in California: How They Work and Calculations (2025)  
(<https://employeesfirstlaborlaw.com/permanent-disability-ratings-in-california-workers-comp-how-they-work-and-what-theyre-worth/>)

Laws, Regulations, and Court Decisions on Diminished Future Earning Capacity (<https://iarp-rehabpro.scholasticahq.com/article/146885-laws-regulations-and-court-decisions-related-to-diminished-future-ear.pdf>)

Permanent Total Disability in California Workers' Compensation: Lifetime Benefits Guide  
(<https://employeesfirstlaborlaw.com/permanent-total-disability-in-california-workers-comp-lifetime-benefits-guide/>)

QME vs. AME in California Workers' Comp: What's the Difference? (<https://employeesfirstlaborlaw.com/qme-vs-ame-in-california-workers-comp-whats-the-difference/>)

DWC Qualified Medical Evaluator (QME) Process Overview (<https://www.dir.ca.gov/dwc/medicalunit/QualificationForQME.html>)

DWC FAQs on QME Process (<https://www.dir.ca.gov/dwc/medicalunit/faqiw.html>)

The Role of Medical Evidence in Workers' Compensation Cases (2025) (<https://katniklaw.com/the-role-of-medical-evidence-in-workers-compensation-cases/>)

Workers' Compensation Dispute Resolution Process in California (<https://dascaniolaw.com/workers-compensation-dispute-resolution-process-in-california/>)

WCAB Significant Panel Decisions ([https://www.dir.ca.gov/wcab/wcab\\_panel.htm](https://www.dir.ca.gov/wcab/wcab_panel.htm))

WCAB En Banc Decisions ([https://www.dir.ca.gov/wcab/wcab\\_enbanc.htm](https://www.dir.ca.gov/wcab/wcab_enbanc.htm))

Apportionment in California Workers' Compensation: Case Law Updates (July 2024) (<https://www.pbw-law.com/apportionments/apportionment-case-law-update-july-2024/>)

California Labor Code Section 4663: Apportionment Principles (<https://www.coa.org/docs/distancelearningcourse/rw/RondeauApportionmentPresentation.pdf>)

GAF Score: Psychiatric Injury Workers Compensation Guide (2025) (<https://www.workinjuryhelp.com/gaf-score-meaning-what-you-need-to-know/>)

Are Psychiatric Injuries Compensable in Workers' Compensation? (2025) (<https://www.shouselaw.com/ca/workerscomp/occupational-injuries/psychological-trauma/>)

Workers' Compensation for Psychological Injuries: Your Rights Explained (2025) (<https://employeesfirstlaborlaw.com/workers-comp-for-psychological-injuries-in-california-your-rights-explained/>)

What Constitutes Substantial Medical Evidence in California (2025) (<https://bpkfirm.com/what-constitutes-substantial-medical-evidence-in-california-lc-4628/>)

Substantial Evidence Standard in Workers' Compensation Appeals (<https://www.casemine.com/commentary/us/reaffirming-the-substantial-evidence-standard-in-workers-compensation:-paulino-v.-diversified-coatings,-inc./view>)

Vigil En Banc Decision and CVC Rebuttal (2024) (<https://www.jdsupra.com/legalnews/wcab-issues-en-banc-decision-providing-9163250/>)

Using the Combined Values Chart (International Reference) (<https://clik.dva.gov.au/military-compensation-srca-manuals-and-resources-library/permanent-impairment-handbook/ch-5-calculation-using-approved-guide/54-combined-values-chart/542-using-combined-values-chart-calculate-cwpi>)

Medical Treatment Utilization Schedule (MTUS) (<https://www.dir.ca.gov/dwc/mtus/mtus.html>)

DWC Evidence-Based Updates to MTUS (Current as of 2026) (<https://www.dir.ca.gov/dwc/dwcpropregs/medical-treatment-utilization-schedule/medical-treatment-utilization-schedule.htm>)

SB 899 Topic Summary Report (<https://www.dir.ca.gov/chswc/SB899summary.html>)

Section-by-Section Review of SB 899 (<https://www.dir.ca.gov/chswc/section-by-section-review-of-sb899.pdf>)

DWC Form 10214(c): Compromise and Release Settlement Form (<https://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWCForm10214c.pdf>)

scribd.com (<https://www.scribd.com/document/93324394/Master-the-Guides-Ch1>)

cwci.org (<https://www.cwci.org/document.php?file=715.pdf>)

dir.ca.gov (<https://www.dir.ca.gov/injuredworkerguidebook/chapter7.pdf>)

jonesclifford.com (<https://jonesclifford.com/success/insurance-companies/>)

jennarouselaw.com (<https://jennarouselaw.com/library-guzman2/>)

acc.co.nz (<https://www.acc.co.nz/assets/provider/ama4-handbook-acc716.pdf>)

wcb.ny.gov (<https://www.wcb.ny.gov/CMS-1500/initial-report.jsp>)

dir.ca.gov (<https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Damien-SMITH-ADJ9808526.pdf>)

nycourts.gov  
([https://www.nycourts.gov/reporter/webdocs/NYCOSH\\_Independent\\_Medical\\_Examinations.htm](https://www.nycourts.gov/reporter/webdocs/NYCOSH_Independent_Medical_Examinations.htm))

dir.ca.gov (<https://www.dir.ca.gov/dwc/pdr1997.pdf>)

cwci.org (<https://www.cwci.org/document.php?file=712.doc>)

wcb.ny.gov (<https://www.wcb.ny.gov/content/main/hcpp/mdguide.pdf>)

visionarylawgroup.com (<https://visionarylawgroup.com/personal-doctor-disagrees-company-doctor/>)

uploads.map-dynamics.com ([https://uploads.map-dynamics.com/1536081611\\_Dr.%20Brigham%20AMA%206th%20Edition%20powerpoint.pdf](https://uploads.map-dynamics.com/1536081611_Dr.%20Brigham%20AMA%206th%20Edition%20powerpoint.pdf))

pmc.ncbi.nlm.nih.gov (<https://pmc.ncbi.nlm.nih.gov/articles/PMC6953445/>)

dol.gov  
([https://www.dol.gov/agencies/owcp/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedp/Unifiedpm\\_part2/Chapter2-1300ImpairmentRatings](https://www.dol.gov/agencies/owcp/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedp/Unifiedpm_part2/Chapter2-1300ImpairmentRatings))

eeoc.gov (<https://www.eeoc.gov/laws/guidance/enforcement-guidance-workers-compensation-and-ada>)

dir.ca.gov (<https://www.dir.ca.gov/wcab/Panel-Decisions-2024/Sammy-VIGIL-ADJ11201607-ADJ11201608.pdf>)

dir.ca.gov (<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>)

ww3.workcompcentral.com  
(<https://ww3.workcompcentral.com/columns/print/id/cc93b8d88ec41daf18c3fda1c9ac01dbj>)

lflm.com (<https://www.lflm.com/news-knowledge/2025-forecast-in-california-workers-compensation/>)

dir.ca.gov (<https://www.dir.ca.gov/DIRNews/2025/2025-115.html>)

judgeobrien.com ([https://judgeobrien.com/index.php?option=com\\_content&view=article&id=1482%3A40-1-1-attorney-fees&catid=20%3Aorbien&Itemid=101](https://judgeobrien.com/index.php?option=com_content&view=article&id=1482%3A40-1-1-attorney-fees&catid=20%3Aorbien&Itemid=101))

roderickstoneburner.com (<https://roderickstoneburner.com/2021/04/evidence-based-ve-and-workers-compensation/>)

dir.ca.gov (<https://www.dir.ca.gov/WCAB/1997-eb2.pdf>)

coa.org (<https://coa.org/docs/AMEQMECourse/Handouts/Ca4628.pdf>)

advocatemagazine.com (<https://www.advocatemagazine.com/article/2019-march/workers-compensation-liens-and-credit-issues>)

lawpartners.com.au (<https://lawpartners.com.au/blog/whole-person-impairment-compensation-calculator-and-guide>)