

California Workers' Compensation QME Reports and Permanent Disability Rating Determination: A Legal Analysis

(PART-A INJURED WORKERS ANALYSIS)

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CALIFORNIA WORKERS' COMPENSATION: HOW QME REPORTS BECOME PERMANENT DISABILITY RATINGS AND HOW TO CHALLENGE THEM

If you were hurt at work in California, a doctor called a Qualified Medical Evaluator (QME) will write a report about your injuries. A government office called the Disability Evaluation Unit (DEU) then turns that report into a number — your permanent disability (PD) rating. That number directly determines how much money you receive. This report explains how the DEU creates your rating, what your rights are, and how you can challenge a rating you believe is wrong.

Important: A difference of even 5–10 percentage points in your permanent disability rating can mean tens of thousands of dollars more or less in benefits. Understanding this process is critical to protecting your rights.

Part 1: The Legal Framework — Laws That Control Your Disability Rating

This part explains the California laws and regulations that give the DEU its authority and set the rules it must follow.

Statutory Authority: The Laws Behind Your Rating

The main law controlling permanent disability ratings is Cal. Lab. Code § 4660 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.&lawCode=LAB). This law says that when deciding your permanent disability percentage, the DEU must consider three things:

- The nature of your physical injury — how serious the damage to your body is
- Your occupation — what job you did when you were hurt
- Your age at the time of injury — how old you were when the injury happened

The law gives special attention to your "diminished ability to compete in an open labor market," meaning how much harder it is for you to find and keep a job because of your injury.

The DEU uses the Permanent Disability Rating Schedule (PDRS) — a set of official tables published by the state. Under Cal. Lab. Code § 4660 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.&lawCode=LAB), this schedule is prima facie evidence (meaning it is treated as correct unless you prove otherwise) of the permanent disability for each type of injury. You have the right to challenge this schedule with proper medical and vocational evidence.

The Administrative Director of the Division of Workers' Compensation (DWC) has the power to create, adopt, and update the PDRS. The schedule must be available for public review.

How Injuries After January 1, 2013 Are Rated Differently

If your injury happened on or after January 1, 2013, a newer law applies: Cal. Lab. Code § 4660.1 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.1.&lawCode=LAB). This law uses a simpler formula. Your doctor's whole person impairment (WPI) rating is multiplied by 1.4 (a 40% increase) instead of using the more detailed adjustment factors from the older schedule.

Important: Under Cal. Lab. Code § 4660.1(c) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.1.&lawCode=LAB), if you develop sleep problems, sexual problems, or a psychiatric condition because of a physical work injury, these conditions generally cannot increase your disability rating. There are narrow exceptions for injuries caused by violent acts or catastrophic events.

The Apportionment Law: Pre-Existing Conditions

Apportionment means dividing your disability between the work injury and any pre-existing condition you already had. Cal. Lab. Code § 4663 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4663.&lawCode=LAB) requires that:

- A physician (not a rater or judge) must make the apportionment decision in writing
- The physician must state the approximate percentage caused by the work injury
- The physician must state the approximate percentage caused by other factors
- The physician must explain the basis for the opinion — the "how and why"

You only receive permanent disability benefits for the portion caused by your work injury. However, the physician cannot simply guess or use default percentages. The apportionment must be based on clear medical evidence.

The DEU's Regulations: Procedural Rules

The DEU follows detailed regulations found in Title 8, California Code of Regulations (8 C.C.R.) (<https://www.dir.ca.gov/t8/10160.html>). The most important regulations are:

- 8 C.C.R. § 10160 (<https://www.dir.ca.gov/t8/10160.html>) — Rules for rating requests from unrepresented workers (workers without an attorney)
- 8 C.C.R. § 10161 (<https://www.dir.ca.gov/t8/10161.html>) — Rules for rating requests from represented workers (workers with an attorney)
- 8 C.C.R. § 10164 (<https://www.dir.ca.gov/t8/10164.html>) — Rules for asking the DEU to reconsider a rating you disagree with

Under 8 C.C.R. § 10160(a) (<https://www.dir.ca.gov/t8/10160.html>), the DEU will only issue a rating after it receives three complete documents:

- A completed DWC AD Form 101 (Request for Summary Rating Determination)
- A completed DWC AD Form 100 (Employee's Disability Questionnaire)
- The QME's complete medical evaluation report

Critical: Your rating request is not considered "received" until all three documents arrive at the correct DEU office. If any document is missing, the 20-day rating deadline does not start.

Part 2: Key Court Decisions That Shape Your Rights

This part covers the most important court and board decisions that define how disability ratings work and when you can challenge them.

The Almaraz/Guzman Rule: Alternative Impairment Ratings

The Workers' Compensation Appeals Board (WCAB) — the court system that handles workers' compensation disputes — has ruled that the PDRS rating method is rebuttable. Under the Almaraz/Guzman doctrine, a QME physician may provide an alternative impairment rating that differs from the strict AMA Guides method if the physician:

1. First performs the standard AMA Guides rating correctly
2. Explains why that standard rating does not accurately describe your impairment
3. Chooses an alternative chart or method from within the AMA Guides
4. Provides complete supporting evidence and reasoning

This means your doctor is not locked into one rigid formula. If the standard method does not capture how severely you are actually impaired, the doctor can use an alternative approach.

Ogilvie v. Workers' Comp. Appeals Bd. (2011)

Ogilvie v. Workers' Comp. Appeals Bd., 76 Cal. Comp. Cases 624 (WCAB en banc 2011) (<https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABENBancOgilvieW.pdf>) is a landmark decision. The WCAB ruled that the diminished future earning capacity (DFEC) part of the PDRS can be challenged with vocational evidence — testimony from an expert about your ability to find and keep a job.

If a qualified vocational expert can show that because of your work injury, you have lost more earning capacity than the PDRS says, you may receive a higher rating. This is especially important if you cannot return to any job in the open labor market.

Vigil v. County of Kern (2024)

Vigil v. County of Kern (WCAB en banc 2024) (https://www.dir.ca.gov/wcab/wcab_enbanc.htm) addressed how ratings for multiple body parts are combined. The DEU normally uses a Combined Values Chart (CVC), which combines impairments in a way that produces a total less than simply adding them together. Vigil ruled that you can challenge the CVC, but only if you show through detailed medical evidence that:

- The effects of your impairments on activities of daily living (ADLs) — things like bathing, dressing, cooking, and walking — do not overlap, OR
- If they do overlap, the overlap makes the combined effect worse than expected (a synergistic effect)

Important: Simply saying "my injuries make each other worse" is not enough. Your doctor must explain exactly which daily activities are affected by each injury and how they interact.

Escobedo v. Marshalls (2005)

Escobedo v. Marshalls, 70 Cal. Comp. Cases 604 (WCAB en banc 2005) (<https://cwilc.com/top-7-proven-legal-strategies-for-challenging-unfair-apportionment-in-california-workers-comp-claims/>) established that apportionment can be based on pre-existing pathology — meaning degenerative conditions like arthritis or disc disease that existed before your work injury, even if you never sought treatment for them. However, the apportionment must rest on substantial medical evidence that explains how the pre-existing condition contributed to your current disability. Vague or speculative reasoning is not enough.

City of Petaluma v. Workers' Comp. Appeals Bd. (2019)

City of Petaluma v. Workers' Comp. Appeals Bd., 29 Cal. App. 5th 1173 (2019) (<https://cwilc.com/top-7-proven-legal-strategies-for-challenging-unfair-apportionment-in-california-workers-comp-claims/>) confirmed that when substantial evidence supports apportionment, the law requires it — apportionment is mandatory, not optional. But the court also held that the apportionment opinion must include a detailed "how and why" explanation. Generic statements like "50% due to aging" are not sufficient.

Schaan v. Jerry Thompson & Sons (2022)

Schaan v. Jerry Thompson & Sons, Cal. Wrk. Comp. P.D. LEXIS 264 (2022) (<https://www.sullivanoncomp.com/blog/vocational-evidence-and-lc-4660.1c>) addressed the interaction between psychiatric injury restrictions under Cal. Lab. Code § 4660.1(c) (https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.1.&lawCode=LAB) and vocational evidence. The WCAB held that even if vocational evidence shows you cannot work at all, a psychiatric impairment cannot be considered in the vocational analysis if the psychiatric condition arises from a physical injury and no statutory exception applies.

Part 3: How the DEU Calculates Your Permanent Disability Rating

This part explains step by step how the DEU turns your QME report into a disability percentage and dollar amount.

The Rating Formula for Injuries Between 2005 and 2012

If your injury happened between January 1, 2005 and December 31, 2012, the DEU uses the 2005 Permanent Disability Rating Schedule (<https://www.dir.ca.gov/dwc/pdr.pdf>) and follows these steps:

1. Determine your WPI — The QME uses the AMA Guides to the Evaluation of Permanent Impairment (5th Edition) to assign a whole person impairment percentage reflecting how much the injury affects your overall body function
2. Apply the DFEC adjustment — The WPI is increased by a factor between 1.1 and 1.4, depending on the type of injury, to account for diminished future earning capacity
3. Apply the occupational modifier — A letter from A (most sedentary job) to J (most physically demanding job) adjusts the rating based on your job duties. A warehouse worker with a back injury gets a higher adjustment than an office worker with the same injury.
4. Apply the age modifier — Your age at the time of injury further adjusts the rating. Generally, older workers receive higher adjustments.
5. Convert to weeks and dollars — The final percentage is converted to weeks of compensation under Cal. Lab. Code § 4658 (https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4658.&lawCode=LAB)

The Simplified Formula for Injuries After January 1, 2013

For injuries on or after January 1, 2013, the process is simpler under Cal. Lab. Code § 4660.1 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.1.&lawCode=LAB):

1. The QME assigns a WPI using AMA Guides (5th Edition)
2. The WPI is multiplied by 1.4 (a flat 40% increase)
3. The result is rounded to the nearest whole number
4. Age and occupation modifiers are applied using the same tables as the older schedule

How Apportionment Reduces Your Rating

If the QME determines that a pre-existing condition contributed to your disability, your rating will be reduced by the apportioned percentage. For example, if your total permanent disability is rated at 40%, but the QME apportions 25% to a pre-existing degenerative disc condition, your compensable disability is 30% (75% of 40%).

The DEU reviews the QME's apportionment analysis but does not make its own medical judgment. The DEU's job is to check whether the QME's reasoning meets the legal standard — not to substitute a different medical opinion.

How Multiple Injuries Are Combined

When you have injuries to more than one body part, the DEU uses the Combined Values Chart rather than simply adding the percentages. For example, a 20% back disability plus a 20% knee disability combines to roughly 35–36% — not 40%. This is because some functional limitations overlap.

Under *Vigil v. County of Kern* (WCAB en banc 2024) (https://www.dir.ca.gov/wcab/wcab_enbanc.htm), you can challenge the CVC if your doctor provides detailed evidence showing that the impairments' effects on daily activities either do not overlap or create a synergistic (amplifying) effect.

Part 4: How to Get a Rating, Review It, and Challenge It

This part walks you through the practical steps for requesting, reviewing, and challenging a DEU permanent disability rating.

Step 1: Requesting a Rating

To request a rating from the DEU, you or your attorney must submit three documents together:

- DWC AD Form 101 — the formal request for a summary rating
- DWC AD Form 100 — a questionnaire about your job, injuries, and daily life
- The QME's medical evaluation report — the doctor's findings about your impairment

You must send these to the DEU office that covers the area where you live. For the San Francisco Bay Area, this is the Northern California DEU Office in Oakland:

> Division of Workers' Compensation, Disability Evaluation Unit

> 1515 Clay Street, 5th Floor, Oakland, CA 94612

> Phone: (510) 286-3700 or 1-800-794-6900

Critical: Make sure all three documents are complete before submitting. Under 8 C.C.R. § 10160(e) (<https://www.dir.ca.gov/t8/10160.html>), your request is not considered "received" until everything is in. An incomplete submission does not start the 20-day clock.

Step 2: The 20-Day Deadline

Under Cal. Lab. Code § 4061(e) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4061.&lawCode=LAB), the DEU must issue your rating within 20 days of receiving your complete request.

If the DEU misses this deadline:

- The claims administrator (your employer's insurance company) may calculate and pay benefits on its own without waiting for the DEU rating
- If the claims administrator unreasonably delays your benefits while waiting for a late rating, you may be entitled to a 25% penalty (up to \$10,000) under Cal. Lab. Code § 5814 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5814.&lawCode=LAB)

Note: Document the exact date you submitted your complete request and track whether the 20-day deadline is met. If it is not, send a written inquiry to the DEU and keep a copy.

Step 3: Reviewing Your Rating

When you receive your rating, check it carefully for these items:

- Correct schedule applied — The rating must use the PDRS that matches your date of injury (1997, 2005, or 2013+)
- Correct impairment percentage — The WPI should match what the QME wrote in the report
- Proper adjustments — Verify that the occupation and age modifiers match the correct tables
- Apportionment — If applied, the rating should explain the basis and show the calculations separately
- Combining method — If multiple body parts are rated, check whether the CVC was used correctly
- Arithmetic accuracy — Look for any math errors in the formula

Step 4: Requesting Reconsideration (If You Disagree)

If you believe the rating is wrong, you must file DWC AD Form 103 (Request for Reconsideration of Summary Rating) within 30 days of receiving your rating. This form must be served on the opposing party (the insurance company).

Under 8 C.C.R. § 10164 (<https://www.dir.ca.gov/t8/10164.html>), you can request reconsideration on only four grounds:

1. The rating was incorrectly calculated — math or formula errors
2. The QME failed to address all issues — the report skipped something it was supposed to cover
3. The QME failed to completely address an issue — for example, mentioning a condition but not explaining apportionment
4. The QME did not follow required procedures — for example, not using AMA Guides properly

Critical: The 30-day deadline is absolute. If you miss it, you lose the right to request reconsideration and must go directly to WCAB litigation. Count 30 calendar days from the date you received the rating (not the date it was issued). File at least 5 days early to allow for service.

Important: Reconsideration cannot be used to argue that the PDRS itself is wrong or that the DEU misapplied the rating schedule. Those challenges must be raised in WCAB litigation.

Step 5: Supplemental QME Reports

If reconsideration is granted because the original QME report missed an issue, either party may request a supplemental QME report — an additional report from the same doctor addressing the specific gap. Under 8 C.C.R. § 10160(f) (<https://www.dir.ca.gov/t8/10160.html>), you should request this within 20 days of receiving the original report. The QME then has 60 days to complete the supplemental report.

The DEU will issue a revised rating based on both the original and supplemental reports.

Part 5: Reasons to Accept or Challenge a DEU Rating

This part helps you understand when it makes sense to accept a rating and when you should challenge it.

When Accepting the Rating May Be the Right Choice

You may want to accept the DEU rating if:

- The QME's impairment rating is well-supported by objective evidence (imaging, test results, functional capacity evaluations)
- The DEU correctly adjusted the rating for your occupation and age

- You need money quickly and a settlement would provide immediate funds
- Challenging the rating would require expensive expert testimony with uncertain results
- You have significant unpaid temporary disability benefits or medical liens that settlement would resolve

Remember: The DEU rating carries a presumption of correctness under Cal. Lab. Code § 4660 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.&lawCode=LAB). The person challenging the rating bears the burden of proving it is wrong with substantial evidence.

When You Should Challenge the Rating

You should seriously consider challenging the rating if:

- The QME report missed an issue — for example, it did not address apportionment of your shoulder injury to a pre-existing rotator cuff tear
- Apportionment lacks explanation — the QME gave a percentage without explaining "how and why" the pre-existing condition contributed to your disability
- The wrong PDRS was applied — the DEU used the schedule for the wrong date of injury
- Math errors exist — there are arithmetic or formula mistakes in the calculations
- You have vocational evidence — a vocational expert can show that your actual loss of earning capacity is greater than what the PDRS says (an Ogilvie rebuttal)
- Multiple injuries were improperly combined — the CVC was used without analyzing whether impairments create a synergistic effect on your daily activities (a Vigil challenge)
- New medical evidence contradicts the QME — post-examination imaging or treatment records show greater impairment than the QME found

What the Insurance Company Will Argue

If you challenge the rating, expect the insurance company to make these arguments:

- The DEU rating is presumptively correct and you have not met your burden of proof
- The QME's opinion is supported by objective medical evidence and should be given deference
- The apportionment analysis, even if not detailed, meets the legal standard
- Your vocational expert's opinion is speculative or conflicts with the QME's medical findings
- Supplemental reports do not materially change the original conclusions

Part 6: Apportionment — A Closer Look at How Pre-Existing Conditions Affect Your Rating

This part provides a detailed look at apportionment — one of the most contested issues in workers' compensation.

What Counts as a "Pre-Existing Condition"

Under the case law interpreting Cal. Lab. Code § 4663 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4663.&lawCode=LAB), "other factors" that can reduce your rating through apportionment include:

- Prior work injuries
- Non-work injuries (car accidents, sports injuries)
- Natural disease progression (degenerative disc disease, arthritis)
- Genetic conditions and hereditary pathology
- Pre-existing conditions that were asymptomatic (not causing any symptoms before the work injury)

However, the physician must explain through substantial medical evidence how each factor actually contributed to your current disability.

Common Apportionment Mistakes You Can Challenge

Many apportionment opinions contain errors that make them vulnerable to challenge:

- Conclusive statements — The QME writes "20% apportionment to degenerative disc disease" but does not explain what specific functional limitations the degenerative condition causes or how that percentage was determined
- Age-based apportionment without evidence — The QME apportions to "age-related wear and tear" without imaging showing age-related changes or explaining how those changes differ from the injury
- Ignoring pre-injury function — If you worked full duty in a physically demanding job for years despite having a degenerative condition, this strongly suggests the condition was not causing disability before the injury
- Apportioning to non-medical factors — A QME cannot apportion to your education level, motivation, or age itself. Apportionment must be based on a medical condition that actually limits your function.

When to Challenge Apportionment vs. When to Accept It

Challenge apportionment when:

- The QME's explanation lacks the "how and why" detail required by *City of Petaluma v. Workers' Comp. Appeals Bd.*, 29 Cal. App. 5th 1173 (2019) (<https://cwilc.com/top-7-proven-legal-strategies-for-challenging-unfair-apportionment-in-california-workers-comp-claims/>)
- Your medical records show you had no symptoms or treatment before the injury
- The apportionment percentage is inconsistent with medical literature
- Your treating physician disagrees with the QME's apportionment

Accept apportionment when:

- The QME provides a detailed, well-reasoned explanation
- Your medical records clearly document symptoms before the injury
- Your own testimony acknowledges pre-injury problems
- Challenging apportionment would require costly expert discovery with a low chance of success

Part 7: Taking Your Case to the WCAB and Beyond

This part explains what happens if you cannot resolve your rating dispute through the DEU and must go to the Workers' Compensation Appeals Board.

Filing a Declaration of Readiness

If reconsideration is denied or does not resolve your dispute, you move your case to the WCAB by filing a Declaration of Readiness to Proceed. This document tells the WCAB you are ready for a hearing.

The case will first be set for a Mandatory Settlement Conference (MSC), where a judge tries to help both sides reach an agreement. If settlement fails, the case goes to trial before a Workers' Compensation Administrative Law Judge (WCALJ).

Preparing for the MSC and Trial

Your attorney should prepare a detailed written MSC statement explaining:

- Why the DEU rating is incorrect, with specific legal citations
- What medical evidence supports a higher rating
- What vocational evidence (if any) supports a finding of permanent total disability
- What procedural defects occurred in the rating process
- Your settlement demands

At trial, you should be prepared to present:

- Your own testimony about your current limitations and inability to work
- The QME's testimony (or testimony from a different qualified medical expert)
- Vocational expert testimony if pursuing an Ogilvie rebuttal
- Medical records and diagnostic imaging
- Evidence of your pre-injury functional status (to rebut apportionment)

San Francisco WCAB: Local Considerations

The San Francisco WCAB is located at 100 Montgomery Street, Suite 800, San Francisco, CA 94104 (<https://www.dir.ca.gov/injuredworkerguidebook/chapter7.pdf>). Experienced practitioners report that judges at this location generally:

- Require detailed written submissions rather than relying on oral argument
- Expect expert declarations to be submitted early in the process
- Impose strict deadlines for evidence and may refuse late submissions without good cause
- Are receptive to Ogilvie vocational rebuttal evidence when supported by credible testimony

Appealing a WCALJ Decision

If the WCALJ rules against you, you may appeal to the full WCAB. However, the WCAB gives significant deference (respect) to the trial judge's factual findings and will reverse only if the findings are not supported by substantial evidence or the law was misapplied.

Reasons to appeal may include:

- Preserving the record for possible future court review
- Requesting remand — asking the WCAB to send the case back to the trial judge to develop the record further
- Raising novel legal questions that may qualify for en banc review (review by the full WCAB panel)

Part 8: Alternative Options and Additional Benefits

This part covers other paths and benefits you should know about.

Settlement Without Litigation

You and the insurance company can settle at any time without going to trial. Two main settlement types exist:

- Compromise and Release (C&R) — You receive a lump-sum payment and typically give up your right to future medical care for the accepted body parts
- Stipulated Award — Both sides agree on a rating, and you receive biweekly payments based on that rating while future medical care generally remains open

Both types require WCAB approval.

Subsequent Injuries Benefits Trust Fund (SIBTF)

If you had a pre-existing impairment before your work injury, and the combination results in 70% or more permanent disability, you may qualify for additional benefits from the SIBTF. This state fund pays extra compensation beyond what the employer's insurance covers, reducing the impact of apportionment.

Supplemental Job Displacement Benefits (SJDB)

If you were injured on or after January 1, 2004, received a permanent partial disability rating, and your employer did not offer you comparable work, you may qualify for an SJDB voucher. This voucher helps pay for education, retraining, or skill-building programs. It does not depend on your specific disability percentage.

Reopening Your Case

If your condition worsens after you receive a rating and settle, you may petition to reopen your case for "new and further" disability. For cases under a Stipulated Award, you generally must reopen within five years of the date of injury.

Part 9: Language Access and Considerations for Immigrant Workers

This part addresses issues that especially affect immigrant workers in the Bay Area.

Your Right to an Interpreter

If you have limited English proficiency, you have the right to an interpreter during your QME examination. When requesting a QME appointment, make sure to notify the doctor's office of your language needs in advance.

When reviewing the QME report, check whether:

- The report notes that an interpreter was used and identifies the interpreter
- The report accurately captures your complaints (pain levels, functional limitations)
- Any confusion about your symptoms could have resulted from a language barrier

Protecting Your Privacy

If you are an immigrant worker, be aware that medical records obtained during the workers' compensation process may contain personal information. Discuss any privacy concerns with your attorney before medical records are shared.

Important: Your immigration status does not eliminate your right to workers' compensation benefits in California. If you were hurt on the job, you are entitled to benefits regardless of your documentation status.

Part 10: Critical Deadlines and Risk Warnings

This part summarizes the most important deadlines. Missing these deadlines can cost you your rights.

Deadline Summary Table

- 30 days — File DWC AD Form 103 (Request for Reconsideration) after receiving your DEU rating — this deadline is absolute
- 20 days — The DEU must issue your rating after receiving a complete request
- 20 days — Request supplemental QME report after receiving original report (for factual corrections)
- 30 days — The QME must issue the report after the examination
- 60 days — The QME must complete a supplemental report after it is requested
- 5 years — Deadline to reopen a case under a Stipulated Award

How to Protect Yourself

1. Keep copies of everything you submit and receive
2. Note the exact date you receive every document
3. Calculate deadlines immediately and put them on your calendar
4. File documents early — do not wait until the last day
5. Always obtain proof of service when filing documents
6. If the DEU misses the 20-day deadline, send a written inquiry and keep a copy
7. If the insurance company delays your benefits, document the delay for a potential penalty claim under Cal. Lab. Code § 5814 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5814.&lawCode=LAB)

Part 11: Contact Information and Resources

Northern California DEU Office

Division of Workers' Compensation, Disability Evaluation Unit

1515 Clay Street, 5th Floor, Oakland, CA 94612

Phone: (510) 286-3700 or 1-800-794-6900

San Francisco WCAB

100 Montgomery Street, Suite 800, San Francisco, CA 94104

DWC Information & Assistance Unit (Free Help for Injured Workers)

Phone: 1-800-736-7401

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

DWC Injured Worker Resources

- DWC Information & Assistance Unit (<https://www.dir.ca.gov/dwc/landA.html>) — Free services for injured workers
- DWC Injured Worker Guidebook — Chapter 7: Permanent Disability Benefits (<https://www.dir.ca.gov/injuredworkerguidebook/chapter7.pdf>)
- DWC QME Information (<https://www.dir.ca.gov/dwc/medicalunit/faqiw.html>)
- DWC Disability Evaluation Unit Homepage (<https://www.dir.ca.gov/dwc/deu.html>)
- DWC FAQs on the PDRS (https://www.dir.ca.gov/dwc/faq/deu_faq.html)

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California Workers' Compensation QME Reports and Permanent Disability Rating Determination: A Legal Analysis

(PART-B LEGAL ANALYSIS)

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Executive Summary

The Disability Evaluation Unit (DEU) of California's Division of Workers' Compensation plays a critical and often determinative role in the workers' compensation system by converting medical evidence from Qualified Medical Evaluators (QMEs) into permanent disability (PD) ratings that directly translate to monetary compensation and ongoing benefit entitlements for injured workers. This report provides a comprehensive analysis of how QME reports are processed, rated, and challenged within California's structured regulatory framework. The research reveals that while the DEU operates under clear statutory and regulatory authority, substantial opportunities exist for injured workers and their representatives to challenge ratings that fail to comply with mandatory procedures, apply incorrect methodologies, or reach conclusions unsupported by substantial medical evidence. The fundamental legal framework rests on Labor Code Section 4660 establishing the Schedule for Rating Permanent Disabilities as prima facie evidence that is nonetheless rebuttable through proper medical and vocational evidence. Ratings issued by the DEU within the statutory 20-day window are accorded significant weight but remain subject to reconsideration, appeal to the Workers' Compensation Appeals Board (WCAB), and ultimately federal court review if constitutional or statutory violations occur.

Key Takeaways:

The DEU issues three categories of permanent disability ratings (summary, formal, and consultative) with different procedural requirements and evidentiary standards applicable to represented versus unrepresented workers. The rating process involves a mandatory 20-day timeline from receipt of a complete QME report; failure to meet this timeline creates remedial opportunities and potential penalty liability for the claims administrator. Injured workers may challenge DEU ratings within 30 days using Form DEU-103 (Request for Reconsideration) on limited but significant grounds: failure to address disputed issues, incomplete addressing of issues, failure to follow prescribed evaluation procedures, or incorrect calculation. The PDRS itself, while statutory, has been repeatedly held to be rebuttable through substantial vocational evidence under the landmark case of *Ogilvie v. WCAB* (2011) 76 CCC 624, establishing that diminished future earning capacity can be proven to exceed the presumptive PDRS rating when medical evidence and credible vocational testimony demonstrate inability to return to the open labor market. The application of apportionment under Labor Code Section 4663 requires substantial medical evidence explaining the "how and why" of nonindustrial contributing factors; conclusory or speculative apportionment analysis is increasingly vulnerable to challenge and reversal under recent WCAB precedent. The stakes are material: a difference of even 5-10 percentage points in a permanent disability rating can result in tens of thousands of dollars in additional compensation, making the DEU rating process and the mechanisms to challenge it among the most important procedural components of any workers' compensation claim.

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I. Legal Framework: Statutory Authority, Regulatory Requirements, and Case Law

A. Statutory Authority Governing Permanent Disability Rating

The foundational statutory authority for permanent disability rating in California is codified in Labor Code Section 4660, which establishes both the requirement for rating and the mandatory factors to be considered. The statute provides that "in determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to the diminished ability of such injured employee to

compete in an open labor market." [1] This formulation creates a three-part analysis that must be performed by the DEU rater: first, assessment of the medical impairment using the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th Edition); second, adjustment of that impairment rating for the worker's occupation and age; and third, consideration of whether apportionment to nonmedical, nonoccupational factors is warranted under Labor Code Section 4663. The statute explicitly grants the Administrative Director of the DWC authority to "prepare, adopt, and from time to time amend, a schedule for the determination of the percentage of permanent disabilities," and mandates that such schedule "shall be available for public inspection, and without formal introduction in evidence shall be prima facie evidence of the permanent disability to be attributed to each injury covered by the schedule." [1]

For injuries occurring on or after January 1, 2013, Labor Code Section 4660.1 applies, introducing a simplified adjustment mechanism using a 1.4 multiplier (representing a 40 percent increase to whole person impairment) rather than the more granular diminished future earning capacity (DFEC) modifiers used for injuries dated between January 1, 2005 and December 31, 2012. [30][54] Labor Code Section 4660.1(c) further restricts the permissible scope of psychiatric impairment ratings, providing that "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," with narrow exceptions for psychiatric injuries resulting from violent acts or catastrophic injuries. [56]

The statutory framework explicitly addresses apportionment by Labor Code Section 4663, which requires that when an employee has sustained a previous injury or condition prior to the industrial injury at issue, the permanent disability shall be apportioned based upon a physician's written opinion establishing the approximate percentage that the industrial injury and the preexisting condition each contribute to the employee's permanent disability. [9] The statute mandates that apportionment determinations be made by a physician and specifically states that "the physician shall make written findings regarding the existence and extent of permanent disability, the approximate percentage of permanent disability caused by the industrial injury, the approximate percentage of permanent disability caused by other factors not arising out of the current industrial injury, and the bases for the physician's opinion." [9] This requirement, codified in Labor Code Section 4663, creates a strict procedural requirement that apportionment must rest on clear, written medical opinion with stated bases-not assumption or default percentages.

B. Regulatory Framework: Title 8 California Code of Regulations

The DEU's rating authority and procedures are governed by comprehensive regulations in Title 8, Chapter 4.5, Subchapter 1.6 of the California Code of Regulations, particularly 8 CCR Section 10160 (Summary Rating Determinations for Unrepresented Employees), 8 CCR Section 10160.1 (Summary Ratings on Treating Physician Reports), 8 CCR Section 10161 (Summary Ratings for Represented Employees), and 8 CCR Section 10164 (Reconsideration of Summary Ratings). [2][14] These regulations establish the procedural prerequisites for a rating request, the forms that must be submitted, the documentation required, and the timeline within which the DEU must respond.

Under 8 CCR Section 10160(a), the DEU will issue a summary rating determination upon receipt of a properly prepared request consisting of: (1) a completed Request for Summary Rating Determination (DWC AD Form 101); (2) a completed Employee's Disability Questionnaire (DWC AD Form 100); and (3) a comprehensive medical evaluation from a Qualified Medical Evaluator. [2][2] The regulation further specifies that no request shall be considered received until all three documents have been received by the DEU office having jurisdiction over the employee's area of residence, creating a bright-line rule that incomplete submissions do not toll the 20-day rating deadline. [2]

The critical timeline requirement is contained in Labor Code Section 4061(e), which mandates that "within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer." [20] This statutory timeline is referenced but not duplicated in the regulations; instead, 8 CCR Section 10164 provides the exclusive grounds upon which reconsideration may be granted, establishing that a request for reconsideration may be granted only if it is shown that: (1) the summary rating was incorrectly calculated; (2) the comprehensive medical evaluation failed to address one or more issues; (3) the comprehensive medical evaluation failed to completely address one or more issues; or (4) the comprehensive medical evaluation was not prepared in accordance with required procedures. [14]

The combination of these statutory and regulatory provisions creates a two-level system: first, the DEU's initial summary rating, which must be issued within 20 days; and second, the administrative reconsideration process, which must be initiated within 30 days of receipt of the summary rating and is limited to the four grounds enumerated in 8 CCR Section 10164.[14] Critically, this system does not permit a worker to challenge the DEU's application of the PDRS or the correctness of the rater's interpretation of the medical evidence at the reconsideration stage; those challenges must proceed directly to litigation before the WCAB (either by Mandatory Settlement Conference or trial after filing a Declaration of Readiness).

The regulatory framework further specifies that the DEU rater has access to the QME report, the Employee's Disability Questionnaire (Form 100), and all medical records submitted with the rating request.[2][2] The DEU does not conduct independent medical examination; rather, it functions purely as a rating calculator and administrative reviewer of the methodology used by the QME physician.[2] This functional distinction-that the DEU rater is not a physician and does not substitute his or her medical judgment for that of the QME-is critical to understanding both the DEU's authority and its limitations.

C. Key Case Law: Binding WCAB Precedent and Appellate Authority

The law governing permanent disability ratings has evolved substantially since the enactment of Senate Bill 899 in 2004, which reformed the PDRS and introduced the mandatory use of AMA Guides impairment ratings. Several binding precedents define how DEU raters must apply the PDRS and when the PDRS is rebuttable.

Matter of Guzman (Almaraz/Guzman Alternative Ratings): The WCAB has held that the PDRS, including the methodology prescribed by the AMA Guides, is prima facie evidence but is nonetheless rebuttable.[16][16] Under the "Almaraz/Guzman" doctrine, a physician may provide an alternative impairment rating that differs from the strict AMA Guides method if the physician: (1) performs the strict AMA Guides rating correctly; (2) explains why that strict rating does not adequately or accurately describe the applicant's impairment; (3) chooses an alternate chart or method within the AMA Guides; and (4) provides complete supporting evidence and reasoning for the alternative approach.[16][16] The DEU, when receiving such an alternative rating, must evaluate whether the physician's reasoning constitutes substantial medical evidence under the standards established in Labor Code Section 4628 and Title 8 regulation Section 10606.

Ogilvie v. WCAB (2011) 76 CCC 624: This landmark en banc decision established that the diminished future earning capacity (DFEC) portion of the 2005 PDRS is rebuttable through vocational evidence.[11][44][46] The WCAB held that applicants may challenge a scheduled rating by demonstrating, through qualified vocational expert testimony, that due to industrial injury they have suffered a greater loss of future earning capacity than reflected in the scheduled rating-specifically, that they are permanently totally disabled and unable to compete in the open labor market.[29][46] This opened the door to awards exceeding the PDRS presumptive rating when medical and vocational evidence demonstrates actual diminished earning capacity in excess of the scheduled amount.

Vigil v. County of Kern (2024) En Banc Decision: The WCAB clarified the procedure for rebutting the Combined Values Chart (CVC) when rating multiple impairments.[21][41] Under this recent decision, when an injured worker has impairments to more than one body part, the CVC-which is the default method for combining impairments-may be rebutted only if the applicant establishes through substantial medical evidence that either: (1) the effects on activities of daily living (ADLs) of each impairment do not overlap; or (2) if they do overlap, the overlap increases or amplifies the impact on the overlapping ADLs.[21][41] The decision emphasizes that merely asserting a "synergistic effect" without detailed analysis of ADL impacts is insufficient; physicians must explain the specific "how and why" of the synergistic relationship.[21][41]

Escobedo v. Marshalls (2005) 70 Cal.Comp.Cases 604 (WCAB en banc): This decision established that under Labor Code Section 4663, apportionment may be based on pathology (degenerative conditions, genetic predispositions) and preexisting asymptomatic conditions, not merely on prior industrial injuries.[9] However, the apportionment must rest on substantial medical evidence that quantifies the approximate percentage of disability attributable to nonindustrial factors-not on general assumptions about aging or disease progression.

Nunes I and Nunes II: The WCAB clarified that apportionment determinations must be made by physicians, and vocational experts may not offer a competing or alternate apportionment analysis.[11][44] Additionally, an award of permanent total disability may issue "so long as the medical and vocational evidence establishes

that the permanent and total disability arises solely out of industrial conditions or factors, that is, exclusive of nonindustrial or prior industrial conditions or factors." [11]

Schaan v. Jerry Thompson & Sons (2022): This case addressed the interaction between Labor Code Section 4660.1(c) (which bars increased impairment ratings for psychiatric disorders arising from physical injuries unless exceptions apply) and vocational evidence of permanent total disability. [56] The WCAB held that even if vocational evidence demonstrates complete inability to return to work, a psychiatric impairment cannot be considered in the vocational analysis if it is a compensable consequence of a noncompensable psychiatric injury and no exception applies.

These cases establish that while the DEU rater must apply the PDRS as a starting point, the DEU's rating is not immune from challenge if substantial medical or vocational evidence demonstrates that the scheduled rating does not accurately reflect the worker's actual permanent disability or if procedural defects occurred in the rating process.

II. Current Legal Landscape (2024-2026): Procedural Developments and Recent Decisions

A. 2024-2025 WCAB Precedent Developments

Vigil v. County of Kern (June 2024) En Banc: As noted above, this decision significantly tightened the evidentiary standard for rebutting the CVC through claims of synergistic effects between multiple impairments. [21][41] The decision requires physicians to provide detailed analysis of how and why overlapping ADLs are amplified rather than merely asserting synergy. This increases the burden on both QMEs providing alternative ratings and workers' attorneys attempting to obtain higher combined impairment ratings at trial. DEU raters must now be attentive to whether a QME's analysis of multiple impairments meets this standard; if it does not, the DEU may face reconsideration or appellate challenges if it relies on unsupported synergistic reasoning.

Rodriguez v. Continuing Life, LLC (2022) Cal. Wrk. Comp. P.D. LEXIS 304: This decision addressed the "mailbox rule" as applied to QME panel strikes, holding that the Administrative Director applying the mailbox extension under CCR Section 10605 must result in uniform application of deadlines. [19] While not directly addressing DEU rating procedures, this case reflects the WCAB's commitment to ensuring that procedural rules are applied consistently and predictably—a principle that extends to DEU rating timelines.

State Compensation Insurance Fund v. WCAB (2024): This case addressed bad faith sanctions in the context of interpreter fee disputes and clarified that reasonably disputing claimed costs does not constitute bad faith warranting Labor Code Section 5813 sanctions. [70] While not a rating case, it reflects evolving WCAB jurisprudence on the scope of bad faith and suggests increasing skepticism toward claims that good faith disputes about evidence or fees constitute sanctionable conduct.

B. DEU Rater Qualification and Training Standards (2025-2026)

As of March 2026, the DWC has not published updated rater qualification standards or training protocols specific to DEU personnel beyond general DWC administrative rules. The qualifications for QME physicians are detailed in 8 CCR Section 11, but no corresponding detailed rater qualification scheme exists for DEU staff members, suggesting they are civil service employees subject to general state personnel standards. [31][32] This gap creates opportunities for challenge: if a rater lacks familiarity with recent WCAB precedent (such as *Vigil's* standards for CVC rebuttal or *Escobedo's* apportionment framework), the resulting rating may be vulnerable to challenge as failure to follow prescribed procedures under 8 CCR Section 10164(a)(4).

C. Regulatory Proposals and Anticipated Changes

No current notice of proposed rulemaking (NPRM) regarding DEU procedures has been published as of March 2026. However, the California Commission on Health and Safety and Workers' Compensation continues to monitor PDRS application and may propose amendments to clarify apportionment procedures or DEU rater training standards in response to recurring disputes about rating accuracy.

D. Processing Backlogs and Service Delays (2025-2026)

The DWC has reported variable DEU processing times, with summary ratings typically issued within the statutory 20-day window for straightforward cases but occasional delays extending beyond 30 days for complex multi-body-part injuries or when supplemental medical information is required.[13][16][59] Workers and their representatives should monitor whether the 20-day deadline is met and, if exceeded, should document the delay as potential grounds for Labor Code Section 5814 penalties (unreasonable delay) against the claims administrator if the delay resulted from the administrator's failure to provide required medical records or properly prepared rating requests.[42]

III. San Francisco-Specific Context: Local Practice Patterns and Regional Considerations

A. San Francisco Immigration Court and Workers' Compensation Appeals Board: Geographic and Administrative Overlap

While the query nominally concerns workers' compensation and not immigration matters, it is important to note that in the San Francisco Bay Area jurisdiction (which includes Oakland, Concord, and surrounding counties), injured workers often face claims involving immigrant workers, workers with language barriers, and workers with intersecting administrative law issues. The San Francisco WCAB location at 100 Montgomery Street, Suite 800, San Francisco, CA 94104 hears cases arising from the Northern California DEU office, which is located in Oakland.[18] Practitioners should note that WCAB judges in the San Francisco area may apply slightly different standards for evaluating QME evidence and may be more or less receptive to vocational rebuttal evidence depending on the individual judge's practice patterns.

B. San Francisco Disability Evaluation Unit Office: Local Processing and Contact Information

The Northern California DEU office, which processes permanent disability rating requests for injuries occurring in the San Francisco Bay Area, is located in Oakland and operates under the administrative direction of the Division of Workers' Compensation's Disability Evaluation Unit.[6][18] Workers and representatives can contact this office directly to inquire about the status of pending ratings or to obtain clarification on the regulatory requirements for requesting reconsideration.[16]

C. San Francisco Workers' Compensation Administrative Law Judges: Known Preferences and Procedural Tendencies

While no published local rules specific to San Francisco WCAB establish unique procedures for challenging DEU ratings, experienced practitioners in the Bay Area report that San Francisco WCAB judges generally require detailed written motions and evidence submission rather than relying on oral argument.[34] This practice suggests that when challenging a DEU rating before the WCAB (whether at MSC or trial), parties should prepare comprehensive written statements explaining why the rating is incorrect and should submit expert declarations or deposition transcripts early in the process.

D. California State Law Interactions: Apportionment and Pre-Existing Conditions in the Bay Area

San Francisco and Northern California have significant populations with pre-existing degenerative conditions, and several prominent cases establishing apportionment standards have originated from the Bay Area.[9] Practitioners should be particularly familiar with *Escobedo v. Marshalls* and its application to prior asymptomatic pathology, as this doctrine frequently applies to construction workers, warehouse workers, and other Bay Area occupational groups.

IV. Strategic Analysis Framework: Pathways to Challenge, Support, and Maximize DEU Rating Outcomes

A. Arguments Supporting Acceptance of a DEU Rating

Statutory Presumption of Correctness: The DEU rating, once issued within the 20-day statutory window and based on a complete and compliant QME report, carries the presumption that it correctly applies the PDRS methodology.[1][4][6] This presumption is rebuttable only through substantial evidence, creating a meaningful burden on the party challenging the rating.

Medical Evidence Fully Supports the Impairment Rating: If the QME's impairment rating is well-supported by objective findings (imaging, testing, functional capacity evaluations) and the QME's analysis complies with AMA Guides standards, and if the DEU rater correctly adjusted that rating for occupation and age, acceptance of the rating avoids the time, expense, and uncertainty of litigation. A worker accepting the rating can proceed

to settlement negotiations with the insurance company, potentially securing a compromise and release or stipulated award that provides certainty of future medical care (if a stipulated award is chosen) or lump-sum settlement funds (if a compromise and release is chosen).

Timing and Settlement Leverage: In some cases, accepting a DEU rating and moving quickly to settlement can provide significant advantages: immediate liquidity, resolution of future medical disputes, and avoidance of protracted WCAB litigation. If the worker has accrued substantial unpaid temporary disability benefits or incurred medical liens, accepting the rating and settling can result in faster payment and potential mitigation of lien costs.

Burden of Proof on the Challenger: Any party challenging the DEU rating bears the burden of proving that the rating is incorrect by substantial evidence.[20][25] This is a meaningful burden, particularly if the challenger must obtain expert testimony to rebut the DEU rater's conclusions.

B. Arguments Favoring Challenge of a DEU Rating

Failure of the QME Report to Address Disputed Issues: If the QME's report fails to address one or more issues that the worker or claims administrator identified in the rating request, this constitutes a ground for reconsideration under 8 CCR Section 10164(a)(2).[14] For example, if the rating request specifically asked the QME to address apportionment of shoulder impairment to a pre-existing rotator cuff tear, but the QME's report is silent on apportionment, the worker should file a request for reconsideration requesting that the QME provide a supplemental report addressing apportionment.

Incomplete Addressing of Issues: Similarly, if the QME addressed an issue but did so incompletely—for example, providing only a conclusory statement about apportionment without explaining "how and why" the nonmedical factor contributed to permanent disability—the worker can request reconsideration on the ground that the issue was not completely addressed.[14]

Failure to Follow Prescribed Procedures: If the DEU rater failed to comply with the mandatory procedures established in Title 8 CCR Section 10160, 10161, or 10164—for example, by failing to apply the correct PDRS schedule based on the date of injury, or by failing to adjust the impairment rating for the worker's age and occupation—this constitutes grounds for reconsideration.[14] A worker should carefully review the rating determination form to verify that the correct rating schedule was applied and that all adjustments were performed.

Incorrect Calculation: Even if the DEU rater properly applied the PDRS methodology, if arithmetic errors or formula errors occurred, the rating was "incorrectly calculated" under 8 CCR Section 10164(a)(1).[14] A review of the rating formula provided by the DEU can identify such errors.

Substantial Medical Evidence Contradicts the QME's Impairment Rating: While a request for reconsideration cannot directly challenge whether the DEU correctly applied the PDRS (that is a question for WCAB litigation), if subsequent medical evidence (such as post-examination imaging, additional functional capacity evaluations, or medical opinions from treating physicians) contradicts the QME's impairment finding, the worker should request a supplemental QME report or consider proceeding to trial before the WCAB with the subsequent evidence.

Vocational Evidence Demonstrates Greater Diminished Future Earning Capacity: Under *Ogilvie* and subsequent case law, vocational expert evidence can rebut the scheduled DFEC rating reflected in the PDRS.[11][29][44][46] If the worker has obtained a vocational expert report demonstrating that due to the industrial injury, the worker cannot return to the open labor market (either in the pre-injury occupation or in any other occupation for which the worker is reasonably suited by age, education, and experience), this evidence should be preserved and presented to a WCAB judge for potential upward adjustment of the rating above the PDRS presumption.

Apportionment Analysis Lacks Substantial Medical Evidence: Under *Escobedo*, *City of Petaluma*, and recent WCAB decisions, apportionment determinations must rest on substantial medical evidence explaining the "how and why" of the nonmedical contribution.[57] If the QME's apportionment analysis is conclusory or speculative (e.g., "30% apportionment due to age-related degeneration" without explanation of the specific mechanism or functional impact), this apportionment is vulnerable to challenge at the WCAB level, and potentially at reconsideration if the DEU rater failed to scrutinize the apportionment adequately.

Multiple Impairment Combining Does Not Meet Vigil Standard: If the worker has impairments to multiple body parts and the QME or DEU applied the Combined Values Chart without analyzing whether the impairments' effects on ADLs overlap or amplify, a challenge under Vigil standards may be available. The worker's attorney should request that the QME provide supplemental analysis of the specific ADLs affected by each impairment and how those ADLs interact.[21][41]

C. Government's Strongest Counterarguments to Rating Challenges

Presumption of Correctness Favors the DEU Rating: The statutory and regulatory framework establishes that the DEU rating is prima facie correct; the burden of proving error rests on the challenger. The government will assert that absent clear evidence of procedural violation or mathematical error, the rating should be upheld.[1][4]

QME's Medical Judgment is Entitled to Deference: If the QME's impairment rating is supported by objective medical evidence and complies with AMA Guides methodology, the claims administrator will argue that the DEU rater appropriately adopted the QME's findings and that absent contrary medical evidence from a qualified medical expert, the rating should not be disturbed.[25][16]

Apportionment is Supported by Substantial Medical Evidence: If the QME provided a narrative explanation of the apportionment determination addressing "how and why" the nonmedical factor contributed, even if that explanation is not detailed, the government will argue that the apportionment meets the Escobedo standard and should not be disturbed. The government will contend that general statements about age, wear and tear, or disease progression, if included in the QME's report as a basis for apportionment, constitute sufficient reasoning.[57]

Vocational Rebuttal Evidence is Speculative or Inconsistent with Medical Findings: If the worker presents vocational expert testimony to rebut the PDRS and prove permanent total disability, the government's strongest response is to argue that the vocational evidence conflicts with the QME's findings that some work capacity remains, or that the worker's own testimony about functional abilities contradicts the vocational expert's opinions. The government may also argue that the vocational expert failed to properly account for the worker's medical impairments or failed to conduct an individualized vocational evaluation.[44][56]

Supplemental QME Reports Do Not Cure Alleged Deficiencies: If the worker requests a supplemental QME report to address alleged gaps in the original report, the government may argue that the supplemental report should not be considered because it is untimely or duplicative, or that the supplemental report's additional detail does not materially change the conclusions already stated in the original report.[33]

V. Permanent Disability Rating Methodology: The PDRS Formula and DEU Rater Application

A. The 2005-2012 Rating Schedule: WPI Adjustment for DFEC, Occupation, and Age

For injuries occurring between January 1, 2005 and December 31, 2012, the DEU rater applies the 2005 Permanent Disability Rating Schedule, which requires the following steps:[30][54]

First, the QME's whole person impairment (WPI) rating is determined using the AMA Guides 5th Edition. The AMA Guides provide specific methodologies for evaluating impairment in different body regions (spine, upper extremity, lower extremity, etc.). The WPI represents a percentage reflecting the degree to which the injury impairs the worker's overall functioning.[30][54]

Second, the WPI is adjusted for diminished future earning capacity (DFEC) using a formula-based approach. The 2005 PDRS establishes seven diminished future earning capacity (FEC) adjustment factors, ranging from 1.1 (10% increase) to 1.4 (40% increase), with intermediate factors for different injury categories.[30][54] The RAND Institute's 2003 study, which forms the empirical basis for the PDRS, established these factors by analyzing the relationship between medical impairments and actual long-term wage loss in California workers' compensation data. The formula accounts for the empirical observation that certain types of injuries (such as psychiatric injuries) correlate with greater long-term wage loss relative to their medical impairment, while others (such as hand injuries) correlate with less wage loss.[30][54]

Third, the DFEC-adjusted rating is then adjusted for the worker's occupation using occupational modifiers designated A through J, where A represents the most sedentary occupations and J represents the most physically demanding.[1][6][30][54] A warehouse worker injured in the back will receive a higher

occupational adjustment than an office worker with the same impairment, reflecting the fact that the warehouse worker's future earning capacity is more significantly impaired if unable to perform heavy lifting.

Fourth, the occupation-adjusted rating is then adjusted for the worker's age at the time of injury using age modifiers found in Section 6 of the 2005 PDRS.[1][6][30][54] Generally, older workers receive higher age adjustments, reflecting the reduced time until retirement and reduced retraining capacity.

The result of these three adjustments is the final permanent disability percentage, which is then converted into weeks of compensation payments based on Labor Code Section 4658, which establishes a schedule correlating permanent disability percentages with compensation weeks (e.g., 0-5% = 0-2 weeks, 5-10% = 2-12 weeks, 10-15% = 12-26 weeks, etc., up to 100% = lifetime benefits plus future medical).

B. The 2013+ Rating Schedule: Simplified 1.4 Multiplier and Restraints on Psychiatric Impairment

For injuries occurring on or after January 1, 2013, Labor Code Section 4660.1 applies, simplifying the adjustment process.[30][16][54] The WPI rating is simply multiplied by 1.4 (representing a 40% increase), rounded to the nearest whole number, and then adjusted for age and occupation using the same modifiers as the pre-2013 schedule.[30][16][54]

Labor Code Section 4660.1(c) further restricts psychiatric impairment by providing that impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder arising from a compensable physical injury shall not increase, with limited exceptions for psychiatric injuries resulting from violent acts or catastrophic injuries.[56] This restriction means that if a worker sustains a physical back injury and develops anxiety or depression as a consequence, the psychiatric impairment cannot be rated separately or added to the back impairment rating unless the injury qualifies as "catastrophic." This provision has generated significant litigation over whether psychiatric consequences can be considered in vocational testimony regarding permanent total disability.[56]

C. Apportionment Reductions Under Labor Code Section 4663

If the worker has a pre-existing condition (whether prior industrial injury, nonoccupational injury, or asymptomatic pathology), Labor Code Section 4663 requires that the physician apportion permanent disability between the industrial and nonmedical factors.[9] The statute requires the physician to determine an approximate percentage of permanent disability caused by the industrial injury and an approximate percentage caused by other factors, with the understanding that the worker receives permanent disability benefits only for the industrial portion.[9]

Recent case law has strictly construed this apportionment requirement. Under *Escobedo*, apportionment may be based on pathology (degenerative conditions) and preexisting asymptomatic conditions, but the apportionment must rest on a clear medical explanation of how the nonmedical factor contributed to the current permanent disability, not merely on the existence of the condition.[9] In *City of Petaluma v. Workers' Compensation Appeals Board*, the Court of Appeal emphasized that where substantial medical evidence shows nonindustrial factors played a causal role in permanent disability, "the Labor Code demands that the permanent disability 'shall' be apportioned," meaning that apportionment is mandatory, not discretionary, if substantial evidence supports it.[12] However, the apportionment percentage must be based on the pathology's contribution to the current disability, not on the percentage of underlying genetics or other etiological factors that caused the pathology.[9]

The DEU rater's task with respect to apportionment is to review the QME's apportionment analysis and determine whether it rests on substantial medical evidence. If the QME provided no apportionment analysis despite clear evidence of a pre-existing condition, the DEU rater should either request a supplemental QME report or issue the rating without apportionment, which may then be subject to challenge by the claims administrator. If the QME provided apportionment analysis that is conclusory or speculative, the DEU rater should critically evaluate whether the reasoning meets the "how and why" standard established by recent case law.

D. Multiple Impairments and the Combined Values Chart: Application and Rebuttal Under Vigil

When a worker has impairments to multiple body parts, the impairments must be combined rather than simply added together. The 2005 PDRS establishes a Combined Values Chart (CVC) that accounts for the expected overlap in functional limitation across different body regions.[1][1] For example, if a worker has both a 20%

permanent disability to the low back and a 20% permanent disability to the right knee, the CVC yields a combined rating less than 40%, typically around 35-36%, reflecting the fact that certain functional limitations (such as bending, lifting, standing) are adversely affected by both conditions but are counted only once in the combined rating.

However, under the Vigil decision, the CVC can be rebutted if the applicant demonstrates through substantial medical evidence that either: (1) the effects of the impairments on activities of daily living do not overlap, in which case the impairments may be added; or (2) if the effects do overlap, the overlap creates a synergistic effect (i.e., the combination amplifies the functional limitation beyond what the AMA Guides and CVC anticipate).[21][41] Vigil requires that any synergistic effect be explained through detailed analysis of specific ADLs and how they are affected by each impairment, not merely through conclusory statements.[21][41]

The DEU rater, upon receiving a QME report that proposes to add impairments rather than use the CVC, should carefully examine whether the QME's analysis complies with Vigil's evidentiary standards. If the analysis is deficient, the DEU may request a supplemental report or apply the CVC despite the QME's recommendation.

VI. Practical Implementation: Procedures for Obtaining, Reviewing, and Challenging DEU Ratings

A. Initial Rating Request: Timing, Forms, and Documentation Requirements

A DEU rating is requested by submitting DWC AD Form 101 (Request for Summary Rating Determination) along with the following documents: (1) the completed DWC AD Form 100 (Employee's Disability Questionnaire); (2) the QME's comprehensive medical evaluation report; and (3) all medical records reviewed by the QME.[2][2] The request must be served on the opposing party (claims administrator or employee, depending on who is requesting the rating).[2]

The timing of the rating request is critical. For unrepresented workers, once the QME report is received, either the injured worker or the claims administrator should promptly request a summary rating so that the 20-day clock begins running.[6][16][59] For represented workers, the parties often agree on a rating or may negotiate settlement without requesting a formal DEU rating; however, if a dispute about the correct rating exists, the party seeking a formal DEU rating should submit the request promptly.[2]

The forms must be completed accurately and completely. 8 CCR Section 10160(e) provides that "no request for a summary rating determination shall be considered until the Employee's Disability Questionnaire, the Request for Summary Rating Determination of Qualified Medical Evaluator's Report, and the comprehensive medical evaluation have been received by the office of the Disability Evaluation Unit having jurisdiction over the employee's area of residence." [2] This means that if any required document is missing or incomplete, the request is deemed not received, and the 20-day deadline does not begin running until all documents are received. Practitioners should submit a complete, well-organized package and follow up with the DEU office to confirm receipt.

B. The 20-Day Timeline and Consequences of Non-Compliance

The statutory deadline for DEU rating issuance is 20 days from receipt of the complete rating request, as established in Labor Code Section 4061(e) and reiterated in 8 CCR Section 10160.[2][20][2] If the DEU fails to issue the rating within 20 days, Labor Code Section 4061(e) provides that "the claims administrator may determine and pay the permanent disability benefits without awaiting the DEU rating." [20]

Additionally, if the claims administrator unreasonably delays providing benefits while awaiting a DEU rating beyond a reasonable time, the worker may be entitled to penalties under Labor Code Section 5814, which allows a 25% penalty up to \$10,000 for unreasonable delay in payment of compensation.[42][68] The worker's attorney should carefully document whether the delay was attributable to the DEU or to the claims administrator's failure to provide medical records or properly prepared rating requests.

C. Review and Analysis of the Issued Rating

Once the DEU issues a rating, the rating determination should be carefully reviewed for the following elements:[2][6][14]

Correct PDRS Applied: The rating should specify which Permanent Disability Rating Schedule was applied (1997, 2005, or 2013+) based on the date of injury and the date the permanent disability was first identified.[16][16][16] If the wrong schedule was applied, this constitutes grounds for reconsideration.[14]

Correct Impairment Rating Used: The DEU rating should cite the specific WPI percentage assigned by the QME. If the DEU used a different impairment rating than that provided by the QME, the rating should explain why.[2][6]

Adjustments Properly Applied: The rating determination should show the occupation and age modifiers applied, and the resulting percentages. The practitioner should verify that these modifiers match those specified in the applicable PDRS.[1][1][54]

Apportionment Correctly Analyzed: If apportionment was applied, the rating should explain the basis (citing the QME's reasoning) and should show the apportioned and non-apportioned percentages separately.[2][14]

Multiple Impairments Correctly Combined: If more than one body part was injured, the rating should specify which combining method was used (CVC or addition) and should show the calculations.[21][41]

Rating Formula: The DEU issues a rating formula that encodes all of these calculations in a standardized notation.[1][1] The practitioner should ensure that this formula is legible and internally consistent.

D. Request for Reconsideration: Timing, Grounds, and Procedure

A request for reconsideration of a DEU rating must be filed within 30 days of receipt of the rating using DWC AD Form 103 (Request for Reconsideration of Summary Rating).[14][40][43] The request must be served on the opposing party and must clearly specify one or more of the four permitted grounds:[14]

The QME or treating physician failed to address all issues.[14]

The QME or treating physician failed to completely address one or more issues.[14]

The evaluation procedures were not followed by the QME or treating physician.[14]

The rating was incorrectly calculated.[14]

Importantly, a request for reconsideration cannot challenge whether the DEU correctly applied the PDRS or whether the PDRS itself is appropriate; those challenges require proceeding to WCAB litigation.[14][20] The reconsideration process is designed to address procedural defects or incomplete medical evaluation, not substantive disagreement with the rating methodology.

When filing a request for reconsideration, the practitioner should provide detailed explanation of which ground is being invoked and should cite specific pages of the medical record supporting the assertion that an issue was not addressed or procedures were not followed.[40][43] For example: "The QME failed to completely address the issue of apportionment of the low back impairment to preexisting degenerative disc disease. The request for summary rating (Form 101) specifically directed the QME to apportion this impairment (page 2, line 5 of the Form 101 request). The QME's report states only that degenerative disc disease was present prior to the injury but does not provide the mandated analysis of how the degenerative disc disease contributed to the current permanent disability or what approximate percentage should be attributed to this nonmedical factor. Pursuant to Labor Code Section 4663 and the requirements established in *Escobedo v. Marshalls*, such apportionment analysis is required and must include the 'how and why' of the contribution." [14]

The DEU's response to the reconsideration request should be issued within a reasonable time (typically 20-30 days, though no specific statutory deadline applies to reconsideration decisions). If the DEU grants the reconsideration, it will typically request a supplemental QME report addressing the deficiency. If the DEU denies the reconsideration, the injured worker or claims administrator may proceed to WCAB litigation to challenge the rating.

E. Supplemental QME Reports and Re-Ratings

If reconsideration is granted because the original QME report failed to address an issue, 8 CCR Section 10160(f) permits either party to request a supplemental QME report within 20 days of receipt of the original

report.[2] The supplemental report should address the specific issue that was not adequately covered in the original report.[2][16]

The supplemental report is then submitted to the DEU, which issues a revised rating based on both the original and supplemental reports. The DEU should clearly indicate which aspects of the rating have changed and which remain the same.[2][16]

If the supplemental report contradicts the original report (e.g., the original report stated 20% WPI and the supplemental report states 25% WPI), the DEU must reconcile the conflicting opinions or indicate that the supplemental report supersedes the original report on specific findings.[2] If the DEU is unable to reconcile the conflict, it may request further clarification from the QME or may submit the conflicting reports to the WCAB with a notation indicating that the DEU was unable to determine which report's findings were correct.[2]

VII. Northern California Implementation Details: San Francisco Bay Area Procedures and Regional Variations

A. Northern California DEU Office: Location, Jurisdiction, and Contact Procedures

The Division of Workers' Compensation maintains a DEU office in Oakland serving Northern California, including the San Francisco Bay Area.[6][18][65] This office has jurisdiction over workers' compensation claims arising from injuries occurring in the counties of Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern (northern portion), Kings, Lake, Lassen, Los Angeles (northern portion), Madera, Marin, Mariposa, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Ventura, and Yuba.[6][18]

Practitioners should contact the Oakland office directly regarding the status of pending ratings. The office can be reached by telephone at (510) 286-3700 or 1-800-794-6900.[13][16] The address is Division of Workers' Compensation, Disability Evaluation Unit, 1515 Clay Street, 5th Floor, Oakland, CA 94612.

B. San Francisco Workers' Compensation Appeals Board: Known Judge Preferences and Hearing Procedures

The San Francisco WCAB location (100 Montgomery Street, Suite 800, San Francisco, CA 94104) hears workers' compensation cases arising from San Francisco County and surrounding areas.[34] While the WCAB does not publish detailed judge-specific preferences, practitioners with extensive Bay Area experience report that the San Francisco judges generally:

Require comprehensive written statements and evidence submission for motions

Favor preparation of detailed Mandatory Settlement Conference (MSC) statements outlining each party's position, evidentiary support, and settlement authority

Expect parties to present expert declarations early in the litigation process rather than relying on live expert testimony

Impose strict time limits for evidence submission and may refuse late-submitted evidence absent good cause

Are receptive to Ogilvie rebuttal evidence when supported by credible vocational testimony and consistent medical evidence

Practitioners should coordinate with the San Francisco WCAB's case management procedures, which may vary from other WCAB locations.

C. Integration with San Francisco Immigration Court and Language Access Issues

While workers' compensation and immigration matters are separate legal domains, the San Francisco Bay Area's significant immigrant worker population means that many workers' compensation cases involve parties with limited English proficiency. Labor Code Section 4060 does not specifically address the provision of interpreters for QME examinations, but the ADA and California law generally require reasonable accommodations for individuals with disabilities or limited English proficiency.

Practitioners should ensure that when requesting QME examinations, the parties notify the QME of any language access needs and ensure that an interpreter is available. Additionally, when reviewing QME reports for workers with language barriers, the practitioner should assess whether the QME adequately documented the worker's ability to communicate, whether an interpreter was used, and whether any confusion about subjective complaints (such as pain levels or functional limitations) may have resulted from language barriers.

D. Northern California Criminal Law and Immigration Consequences: Emerging Intersection

While not directly relevant to DEU rating procedures, practitioners serving immigrant workers should be aware that criminal convictions can affect workers' compensation benefits in certain circumstances (e.g., benefits may be reduced or forfeited if the worker committed a crime related to the workplace injury). Additionally, in rare cases, a workers' compensation claim can generate evidence (such as medical records documenting immigration status) that could have immigration consequences. Practitioners should carefully review privilege and confidentiality issues before obtaining medical records from QMEs when immigrant clients are involved.

VIII. Apportionment and Nonmedical Contributing Factors: Deep Analysis and Strategic Implications

A. The Statutory Framework: Labor Code Section 4663 and Its Judicial Interpretation

Labor Code Section 4663 requires that when an employee has sustained a previous injury or condition, "the permanent disability, as defined in Section 4662, shall be apportioned pursuant to Section 4663."^[9] The statute mandates that "the physician shall make written findings regarding... the approximate percentage of permanent disability caused by the industrial injury, [and] the approximate percentage of permanent disability caused by other factors not arising out of the current industrial injury."^[9] The statute explicitly requires that the apportionment determination be made by a physician and be based on medical evidence, not on subjective evaluation or assumptions.^[9]

The definition of "other factors" under Section 4663 has been interpreted by the courts to include: (1) prior industrial injuries; (2) nonoccupational injuries; (3) natural disease progression; (4) genetic predispositions and pathology; (5) preexisting asymptomatic conditions; and (6) in some cases, age-related changes.^{[9][12][57]} However, the court decisions have consistently required that the apportionment rest on substantial medical evidence establishing a causal relationship between the nonmedical factor and the current permanent disability—not merely on the fact that the nonmedical factor exists or has some pathological significance.

B. Escobedo v. Marshalls: Apportionment to Pathology and Preexisting Conditions

Escobedo v. Marshalls (2005) 70 Cal.Comp.Cases 604 (WCAB en banc) is perhaps the most influential decision interpreting Labor Code Section 4663. The WCAB held that apportionment could be based on preexisting pathology (degenerative disc disease, arthritis) even if the employee had never sought treatment for that pathology and had no prior workers' compensation award.^[9] This holding reversed the pre-2004 rule that apportionment could generally be made only to prior industrial injuries or to recognized prior medical conditions that had been treated.

However, *Escobedo* also emphasized that the apportionment must be quantified: the physician must determine an approximate percentage of permanent disability attributable to the preexisting pathology versus the industrial injury, and this percentage must rest on clear medical evidence showing how the pathology contributed to the current disability.^[9] The WCAB rejected apportionment based on mere speculation or generic references to disease progression.

C. City of Petaluma v. WCAB: The Mandatory Nature of Apportionment and the "How and Why" Standard

City of Petaluma v. Workers' Compensation Appeals Board (2019) 29 Cal.App.5th 1173 (a Court of Appeal decision controlling throughout California) reaffirmed that where substantial medical evidence demonstrates that nonmedical factors contributed to permanent disability, "the Labor Code demands that the permanent disability 'shall' be apportioned."^[12] The court emphasized that apportionment is not discretionary; if substantial evidence supports it, the judge must apportion.^[12]

Critically, *Petaluma* also established that apportionment opinions must include detailed explanation of "how and why" the nonmedical factor contributed to the permanent disability.^{[12][57]} Generic statements such as

"50% apportionment due to age and degeneration" are insufficient; the physician must explain the specific mechanism by which the nonmedical factor impaired function and must quantify the percentage based on this reasoning, not on assumptions.[12][57]

D. Benson v. WCAB: Successive Industrial Injuries and Separate Apportionment Analysis

Benson v. WCAB (1978) 44 Cal.App.3d 981 addresses the situation where a worker has sustained two or more industrial injuries on different dates. Benson requires that permanent disability be separately apportioned to each date of injury unless the permanent disability is truly indivisible between them.[57] This principle is important because it prevents a current employer from escaping liability for disability by claiming that all disability results from a prior industrial injury.

Under Benson, if a worker sustained a back injury in 2015 and a shoulder injury in 2023, and the current impairment involves both the back and shoulder, the physician should separately quantify disability attributable to the 2015 injury and disability attributable to the 2023 injury (if possible) rather than lumping them together.[57] This requirement creates evidentiary burdens for both the worker and the employer: the worker must prove that the current injury caused distinct disability beyond the prior injury, while the employer must prove that prior injury remains a contributing factor to current disability.

E. Common Apportionment Mistakes and Successful Challenges

Conclusory Apportionment Without Medical Basis: If a QME provides a percentage apportionment (e.g., "20% apportionment to preexisting degenerative disc disease") without explaining how this percentage was derived, what specific functional limitations result from the preexisting condition, or what mechanism links the preexisting condition to the current disability, this apportionment is vulnerable to challenge as not constituting substantial medical evidence. The worker or claims administrator seeking to challenge this apportionment should retain an orthopedic expert to provide a supplemental opinion addressing the "how and why" question.[57]

Age-Related Apportionment Without Specific Findings: Similarly, if a QME apportions disability to "age-related degeneration" without providing imaging showing age-related changes, without explaining how age-related changes differ from the injury-related changes, or without quantifying the functional loss from each source, this apportionment is vulnerable to attack.[57] The challenging party should provide prior medical records showing whether the age-related condition was symptomatic or asymptomatic before the injury, whether imaging showed the condition before the injury (if available), and whether the worker's functional status changed after the injury despite the preexisting condition being present.

Failure to Consider Pre-Injury Functional Status: A strong challenge to apportionment involves evidence that despite the preexisting condition, the worker was functioning fully before the injury. If medical records from before the injury show no treatment for the alleged preexisting condition, or if the worker's job history shows years of full-duty work in physically demanding positions despite the alleged preexisting pathology, this suggests that the preexisting condition was not materially contributing to functional loss before the injury and therefore should not be apportioned at high percentages after the injury.

Improper Apportionment to Non-Pathological Factors: While Escobedo permits apportionment to pathology and preexisting conditions, Labor Code Section 4663 does not explicitly permit apportionment to factors such as the worker's education, motivation, or age per se (only to the extent these factors have resulted in actual pathology or functional limitation). A QME that apportions to "inability to retrain due to age" without identifying a specific medical impairment limiting retraining capacity is exceeding the scope of medical apportionment and improperly entering the realm of vocational assessment.

F. Strategic Implications: When to Challenge Apportionment and When to Accept It

Challenge Apportionment When: (1) The QME's analysis lacks "how and why" explanation; (2) prior medical records show the worker functioned normally despite the alleged preexisting condition; (3) the apportionment percentage is inconsistent with medical literature on the condition; (4) imaging or diagnostic testing shows the preexisting condition is asymptomatic or minor; or (5) the apportionment conflicts with consistent statements by the treating physician that the industrial injury is the predominant cause of current disability.

Accept Apportionment When: (1) The QME provides detailed explanation of the mechanism and basis for apportionment; (2) prior medical records clearly document the preexisting condition was symptomatic and

impairing before the injury; (3) the apportionment percentage aligns with medical literature; (4) the worker's own testimony acknowledges pre-injury symptoms from the alleged preexisting condition; or (5) challenging the apportionment would require extensive expert discovery and is unlikely to succeed given the strength of the medical evidence.

IX. Preservation and Appeal Strategy: From DEU Rating Through WCAB Litigation to Federal Court

A. Immigration Court Level Analogy: Preserving Issues for Appellate Review

While the workers' compensation system differs substantially from the immigration system, the principle of preserving issues for appeal applies equally. If an injured worker disagrees with a DEU rating but cannot obtain reconsideration or settlement, the worker must proceed to WCAB litigation. However, at the WCAB level, the worker should carefully preserve arguments about procedural defects or DEU rater errors that might later support a habeas corpus petition or administrative law petition in federal court.

Specifically, when filing a Declaration of Readiness to Proceed before the WCAB, the worker's attorney should clearly identify which aspects of the DEU rating are being challenged, the legal basis for the challenge (procedural defect, failure to apply correct PDRS, incorrect apportionment, etc.), and the evidence supporting the challenge. This record-building is essential because if the WCAB affirms the DEU rating despite the worker's detailed objections, the federal court will have a clear record of the claims made and can assess whether constitutional or statutory rights were violated.

B. WCAB Level Strategy: MSC Statement Preparation and Evidence Submission

When a workers' compensation case proceeds to WCAB litigation, the typical first step is a Mandatory Settlement Conference (MSC), where a judge attempts to broker settlement.^{[34][25]} The worker's attorney should prepare a detailed MSC statement explaining:

Why the DEU rating is incorrect (with specific citations to the PDRS, apportionment case law, Vigil standards for CVC rebuttal, etc.);

What medical evidence supports a higher rating;

What vocational evidence (if any) supports permanent total disability or substantial Ogilvie rebuttal;

What procedural defects occurred in the DEU rating process;

The worker's settlement authority and settlement demands.

The MSC statement should cite controlling WCAB precedent and Court of Appeal decisions and should distinguish adverse authority. The statement should be accompanied by expert declarations (from QME physicians, vocational experts, or other specialists) that can be presented at trial if settlement is not achieved.

If settlement is not achieved at MSC, the case will be scheduled for trial before a workers' compensation administrative law judge (WCALJ). At trial, the worker's attorney should present:

Testimony from the injured worker regarding current functional limitations, job search efforts, and reasons for inability to return to work;

Testimony from the original QME (or a new QME if the original QME is unavailable), addressing the accuracy of the impairment rating and responding to any contrary evidence;

Testimony from a vocational expert (if pursuing an Ogilvie rebuttal for permanent total disability);

Medical records and diagnostic imaging supporting the impairment rating;

Evidence regarding prior medical status (to rebut apportionment claims).

The trial will focus on whether the worker has proven, by a preponderance of the evidence, that the DEU rating is incorrect. The WCALJ's decision will typically affirm, reduce, or increase the DEU rating based on the evidence presented.

C. BIA Appeal Level Strategy: When and Why to Appeal WCALJ Decisions

If the WCALJ issues a decision adverse to the worker, the worker may appeal to the WCAB. However, the WCAB reviews WCALJ decisions under a limited standard: the WCALJ's findings of fact (credibility determinations, assessments of whether medical evidence is substantial) are given significant deference, and the WCAB will reverse only if the findings are not supported by substantial evidence or if the law was misapplied.[25] This deferential standard makes WCAB appeals difficult to win; the appellate board will rarely overturn a WCALJ's determination that a particular QME's opinion is credible and constitutes substantial evidence.

However, appeals may be strategic for several reasons:

Preservation for Federal Court: Even if an appeal is unlikely to succeed, it creates a full appellate record that can support later federal court review on administrative law or constitutional grounds.

Reconsideration and Further Development: The WCAB may remand for further development of the record if it believes the WCALJ failed to adequately address apportionment, CVC rebuttal, or other issues.

Certification Instead of Appeal: In some cases, rather than filing a full appeal, the worker's attorney may request that the WCAB certify the case for further consideration on specific issues (such as whether apportionment analysis meets the "how and why" standard). This certification can expedite appellate review of narrow legal questions.

En Banc Potential: If the case raises novel legal questions or conflicts with existing WCAB precedent, the attorney may request en banc review, where the full WCAB panel reconsiders a panel decision. Recent en banc decisions (such as *Vigil*) have significantly impacted permanent disability law, showing that appellate review can result in important legal developments.

D. Federal Court Challenge: Habeas Corpus and Administrative Procedure Act Claims

If administrative remedies have been exhausted (DEU reconsideration and WCAB litigation), and if the worker believes the DEU rating or WCAB decision violated constitutional or statutory rights, federal court review may be available through a habeas corpus petition or administrative law petition.

Habeas Corpus: Under federal law, a habeas corpus petition may be available if the state decision was based on an unreasonable application of federal law or if it reflected a novel and unsettled proposition of law.[26] However, most workers' compensation determinations do not implicate federal constitutional rights, making habeas petitions unlikely to succeed. The worker would need to demonstrate that the DEU rater or WCALJ violated, for example, due process rights to a hearing, equal protection rights, or substantive rights under federal law.

Administrative Procedure Act (APA) Claims: If the DEU or DWC action was taken in violation of federal administrative law standards, an APA petition might be available in federal court. For example, if the DEU issued a rating in violation of the notice-and-comment procedures required by the Administrative Procedure Act, or if the DEU's action was "arbitrary and capricious" under the APA standard, federal court review might be available. However, this remedy is rarely used in workers' compensation cases because most DEU actions involve application of existing regulatory standards to specific facts, not adoption of new interpretations that would trigger APA procedural requirements.

Injunctive Relief and Mandamus: In rare cases, a worker might seek federal court injunctive relief or a mandamus petition if the DEU or claims administrator is violating California law in a systematic manner (e.g., consistently failing to meet the 20-day rating deadline, systematically ignoring WCAB precedent). However, such petitions are extremely rare and require showing that state remedies are inadequate.

E. Pending Litigation and Potential Circuit Splits

As of March 2026, no circuit split exists on core workers' compensation permanent disability rating issues because workers' compensation law is primarily state law, and federal courts have limited jurisdiction over such cases. However, the following categories of litigation are ongoing and may affect future DEU rating procedures:

Apportionment and Non-Industrial Contributing Factors: Ongoing litigation in various California venues continues to refine the Escobedo and Petaluma standards, with recent cases pushing for more rigorous "how and why" analysis.

Vocational Evidence and Ogilvie Rebuttal: Recent WCAB decisions (such as Schaan and Walsh) have clarified but also restricted the use of vocational evidence, particularly in cases involving psychiatric consequences or apportionment to pre-existing conditions.

CVC Rebuttal and Synergistic Effects: The Vigil decision significantly tightened the evidentiary standard for claiming synergistic effects between multiple impairments; ongoing litigation will test the boundaries of this decision.

Remote and Hybrid QME Examinations: The COVID-19 pandemic led to increased use of remote QME examinations, and ongoing litigation addresses whether remote examinations provide adequate evidence for rating purposes.

X. Alternative Strategies and Contingencies: Options if DEU Rating Dispute Becomes Protracted

A. Settlement Negotiations Without WCAB Litigation

If the DEU rating has been issued and reconsideration has been denied or not pursued, the parties may still negotiate a settlement without proceeding to WCAB litigation. In many cases, this settlement path is faster and less expensive than litigation. The worker and claims administrator can agree on a Compromise and Release (C&R) or Stipulated Award that differs from the DEU rating, subject to WCAB approval.

Compromise and Release: Under a C&R, the worker receives a lump-sum settlement covering all permanent disability benefits (calculated based on the agreed rating, which may differ from the DEU rating) and typically releases all claims to future medical care for the accepted body parts (though in some cases, medical care may be included in the settlement). The C&R must be approved by the WCAB to be binding.

Stipulated Award: Under a Stipulated Award, the worker and employer stipulate to a specific permanent disability rating, which results in ongoing biweekly PD benefit payments based on that rating. Future medical care typically remains open for the accepted body parts, and the worker retains the right to petition to reopen the case for "new and further" disability within five years of the date of injury.

Both settlement options offer the advantage of certainty: the worker knows exactly what benefit they will receive and can plan accordingly. However, both options require that the worker forego the opportunity to obtain a higher rating through WCAB litigation.

B. Uninsured Employers Benefits Trust Fund (UEBTF) Claims

If the worker's injury was caused by an employer who was uninsured at the time of injury, the worker may pursue a claim against the UEBTF, which is a state fund established to provide benefits when uninsured employers fail to pay workers' compensation benefits. The UEBTF will issue its own determination of permanent disability rating (often using the same DEU procedures) and will pay benefits directly to the worker. UEBTF claims have different procedural requirements and may involve somewhat different rating practices, but the underlying PDRS methodology remains the same.

C. Subsequent Injuries Benefits Trust Fund (SIBTF) Claims

If the worker had a pre-existing impairment or disability at the time of the current industrial injury, and if the combined effect of the pre-existing impairment and the current injury results in permanent disability of 70% or more, the worker may be entitled to benefits from the Subsequent Injuries Benefits Trust Fund (SIBTF). The SIBTF provides additional compensation beyond what the employer would normally be liable for, effectively reducing the impact of apportionment. However, SIBTF claims have specific eligibility requirements and procedural rules.

D. Reopening of Claims for "New and Further" Disability

If the worker has received a permanent disability rating and settlement but subsequently develops new or worsening disability related to the same injury, the worker may petition to reopen the case (within five years of the date of injury for cases under a Stipulated Award, or in limited circumstances even after five years). A

petition to reopen will typically require a new medical examination and new permanent disability rating reflecting the additional disability.

E. Supplemental Job Displacement Benefits (SJDB)

Workers injured on or after January 1, 2004 who have received a permanent partial disability rating and have not been offered comparable work by their employer may be entitled to a Supplemental Job Displacement Benefit (SJDB)-a non-transferable voucher that can be used to pay for educational retraining or skill enhancement. The SJDB does not depend on the specific permanent disability rating but rather on whether the worker qualifies under Labor Code Section 4658.5 criteria. Injured workers should ensure they claim the SJDB if eligible, as it provides valuable retraining support.

XI. Ethical Considerations and Professional Responsibilities in DEU Rating Disputes

A. California Rules of Professional Conduct: Duty of Competence and Communication

California Rules of Professional Conduct Rule 1.1 requires that an attorney provide competent representation, which includes "the legal knowledge, skill, preparation and thoroughness reasonably necessary for the representation."^[33] This standard means that an attorney representing a worker in a permanent disability rating dispute must be familiar with the PDRS, applicable case law (including Escobedo, Petaluma, Ogilvie, Vigil, and other controlling precedents), and the specific procedural requirements for requesting reconsideration and pursuing WCAB litigation. An attorney who is unfamiliar with permanent disability rating methodology risks providing incompetent representation.

Similarly, Rule 1.4 requires that an attorney communicate with the client regarding "the objectives and scope of the representation" and "keep the client reasonably informed about the status of the matter."^[33] This means the attorney must explain to the client how the DEU rating was calculated, what grounds exist for challenging it, what the realistic prospects for obtaining a higher rating are, and what the timeline and costs of litigation would be.

B. Duty to Preserve and Present Medical Evidence

An attorney representing a worker in a rating dispute must ensure that all relevant medical evidence is preserved and presented. This includes:

Obtaining and reviewing all treating physician records prior to the QME examination;

Providing the treating physician records to the QME in a timely manner;

Preparing a detailed cover letter (under Labor Code Section 4062.3 requirements) directing the QME to specific issues that should be addressed;

Requesting supplemental QME reports if the initial report fails to address issues;

Obtaining vocational expert evidence if an Ogilvie rebuttal is being pursued;

Preserving expert reports and maintaining communication with experts to ensure they are available for deposition and trial.

Failure to preserve or present available evidence may constitute ineffective assistance or breach of fiduciary duty to the client.

C. Candor to the Workers' Compensation Judge and WCAB

California Rules of Professional Conduct Rule 3.3 requires candor to the court, which extends to workers' compensation judges and the WCAB. An attorney must:

Not present evidence known to be false;

Disclose controlling adverse authority (even if the opposing party has not cited it);

Not present arguments that are frivolous or solely intended to delay;

Correct misstatements of fact or law if discovered.

These duties mean that if an attorney discovers that the client's testimony regarding functional limitations is inconsistent with medical evidence, or if a key precedent actually supports the opposing party's position, the attorney must acknowledge this and adjust the litigation strategy accordingly.

D. Conflicts of Interest and Client Relationships

An attorney representing a worker in a permanent disability rating dispute must ensure that no conflicts of interest exist. For example, if the same attorney previously represented the claims administrator or employer in other matters, conflicts may arise that require the attorney to withdraw from representation. Additionally, if the worker is seeking representation, the attorney should clarify whether the attorney will be handling the entire workers' compensation claim or only the rating dispute, and should establish clear fee arrangements (typically contingent fees in workers' compensation cases, but some arrangements may be hourly or fixed-fee).

E. Obligations When DEU Raters or Physicians Appear to Have Acted Improperly

If an attorney discovers evidence that a DEU rater or QME physician has acted improperly (e.g., deliberately manipulated calculations, excluded relevant evidence, or provided a patently biased opinion), the attorney should consider reporting this conduct to the appropriate authority. For QMEs, complaints can be filed with the DWC Medical Unit. For DEU raters employed by the state, complaints can be filed with the DWC Administrative Director or the state personnel agency. However, the attorney should be cautious about making unfounded accusations, as doing so could expose the attorney to liability for defamation or abuse of process.

XII. Risk Warnings and Key Deadlines: Critical Timing Issues in DEU Rating Disputes

A. The 30-Day Deadline for Request for Reconsideration

The single most important deadline in the DEU rating process is the 30-day deadline for filing a Request for Reconsideration (Form DEU-103). This deadline is absolute and is not subject to extension except in extraordinary circumstances. If the deadline is missed, the worker loses the right to request reconsideration and must proceed directly to WCAB litigation.[14] To avoid missing this deadline:

Calculate the date of receipt of the DEU rating (not the date issued, but the date the rating determination notice was received by the worker or attorney);

Add 30 days (calendar days, not business days);

File the Request for Reconsideration at least five days before the deadline to ensure timely service on the opposing party;

If the deadline falls on a weekend or holiday, verify whether the statutes/regulations extend the deadline (generally, deadlines are extended only if they fall on a non-business day and the next business day filing would be timely)[22][24];

Maintain proof of service showing that the Request for Reconsideration was served on the opposing party within the 30-day period.

B. The 20-Day Timeline for DEU Rating Issuance and Consequences of Non-Compliance

If the DEU fails to issue a rating within 20 days of receipt of a complete rating request, Labor Code Section 4061(e) provides that the claims administrator may issue its own rating determination without awaiting the DEU rating.[20] However, this provision does not prevent the worker from later challenging the claims administrator's rating or requesting a formal DEU rating through WCAB litigation. Additionally, if the claims administrator unreasonably delays benefits pending the DEU rating, the worker may have a claim for Labor Code Section 5814 penalties.[42]

To protect the worker's rights:

Document the date the complete rating request was submitted to the DEU;

Track whether a rating is issued within 20 days;

If no rating is issued within 20 days, send a letter to the DEU inquiring about the status and requesting expedited issuance;

If the delay extends significantly beyond 20 days and the claims administrator has not issued an interim rating, consider filing a Declaration of Readiness to Proceed before the WCAB, which will trigger a hearing on the rating issue without awaiting the DEU determination.

C. QME Report Timeline and Timing of Rating Requests

The QME has 30 days from the date of the examination to issue the report.[59] If the report is not issued within 30 days, 8 CCR Section 38 allows either party to request a replacement QME.[59] For unrepresented workers, the claims administrator must provide a copy of the QME report within a specified timeline.[2]

To protect the worker's interests:

Ensure that the QME knows the date of the examination and that the 30-day timeline applies;

Follow up with the QME office if the report is not received within 30 days;

Coordinate with the claims administrator to request a replacement QME if the original QME is unable to meet the deadline.

D. Timing of Supplemental QME Requests

If a party wishes to request a supplemental QME report to address gaps or deficiencies in the original report, the request should be submitted within 20 days of receipt of the original report (for factual corrections) or after the DEU has issued its initial rating (for requests to address issues not completely addressed in the original report).[2][2] The QME then has 60 days to issue the supplemental report.[16][59] These timelines are important because they determine when a revised DEU rating might be issued and when settlement or litigation decisions should be made.

E. Statute of Limitations and Repose for Rating Disputes

While there is no explicit statute of limitations for challenging a DEU rating, the 30-day reconsideration deadline effectively creates a cut-off point after which administrative remedies are exhausted and the worker must proceed to WCAB litigation. However, even after reconsideration is denied, the worker retains the right to pursue WCAB litigation by filing a Declaration of Readiness to Proceed. There is no statute of limitations on WCAB litigation, but practical factors (such as the worker's statute of limitations to pursue civil litigation for third-party liability, or the statute of limitations for pursuing penalties under Labor Code Section 5814) may limit the window for obtaining relief.

XIII. Appendices: Statutes, Regulations, Forms, and Precedent References

Appendix A: Statutory Provisions Governing Permanent Disability Rating

Labor Code Section 4660: Schedule for Rating Permanent Disabilities

Section 4660 provides the foundational authority for the Schedule for Rating Permanent Disabilities and requires that ratings account for the nature of the injury, occupation, and age of the employee. The section establishes the prima facie evidentiary effect of the Schedule while preserving its rebuttability. The key language states: "In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to the diminished ability of such injured employee to compete in an open labor market." [1]

Labor Code Section 4660.1: Amended Schedule for Injuries on or After January 1, 2013

Labor Code Section 4660.1 applies to injuries occurring on or after January 1, 2013 and simplifies the adjustment mechanism to a 1.4 multiplier applied to the AMA Guides whole person impairment rating. The section further restricts psychiatric impairment ratings by providing that "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" unless narrow exceptions apply.[30][54]

Labor Code Section 4661: Permanent and Stationary Determination

Section 4661 requires that the treating physician determine whether an employee's condition is permanent and stationary (i.e., has reached Maximum Medical Improvement) and must make written findings regarding the existence and extent of permanent impairment. This determination triggers the requirement for permanent disability rating.[1]

Labor Code Section 4662: Permanent Total Disability

Section 4662 defines permanent total disability as a condition in which the employee has sustained a total loss of earning capacity. Certain impairments (such as blindness, loss of both arms, etc.) are conclusively presumed to be totally disabling. Other cases require medical and vocational evidence to establish total disability.[1]

Labor Code Section 4663: Apportionment of Permanent Disability

Labor Code Section 4663 requires apportionment when a pre-existing condition contributed to permanent disability. The section mandates written physician findings regarding the approximate percentage of disability attributable to the industrial injury and to other factors.[9]

Labor Code Section 4664: Accumulation of Permanent Disability

Section 4664 addresses how multiple permanent disability awards (from different dates of injury or different body parts) are combined or accumulated. The section establishes the framework for successive injury analysis and the determination of whether combined disability exceeds threshold levels for various benefits programs.[1]

Labor Code Section 4061: Determination of Permanent Disability

Section 4061 requires the employer to provide notice to an injured worker regarding permanent disability benefits and establishes the procedures for obtaining medical evaluations when disputes arise. The section mandates that the Administrative Director issue a permanent disability rating within 20 days of receipt of a comprehensive medical evaluation.[20]

Appendix B: Regulatory Provisions Governing DEU Rating Procedures

Title 8, California Code of Regulations Section 10160: Summary Rating Determinations for Unrepresented Employees

This regulation establishes the procedure for requesting a summary rating determination from the DEU for unrepresented workers. The regulation requires submission of Form 101, Form 100, and the comprehensive medical evaluation, and specifies that no request is complete until all three documents are received.[2][2]

Title 8, California Code of Regulations Section 10161: Summary Rating Determinations for Represented Employees

This regulation establishes similar procedures for represented workers but provides for different procedural steps involving the worker's attorney and agreement on the medical evaluator selection.[2]

Title 8, California Code of Regulations Section 10164: Reconsideration of Summary Ratings

This regulation establishes the grounds for reconsideration and the timeline (30 days from receipt of the rating) for filing a reconsideration request.[14] The grounds are limited to: (1) incorrect calculation; (2) failure to address all issues; (3) failure to completely address issues; or (4) failure to follow procedures.[14]

Title 8, California Code of Regulations Section 4062.3: Communications with QMEs

This regulation restricts ex parte communications with QMEs and requires that any information provided to a QME be served on the opposing party in advance. The regulation is critical for understanding what communications are permissible and what communications may result in a compromised or inadmissible medical report.[62]

Appendix C: Key WCAB Precedent Decisions (Selected Citations)

Ogilvie v. WCAB (2011) 76 CCC 624

Binding en banc decision establishing that the PDRS is rebuttable through vocational evidence demonstrating diminished future earning capacity exceeding the scheduled rating.[11][29][44][46]

Vigil v. County of Kern (2024) En Banc Decision

Binding en banc decision clarifying the standard for rebutting the Combined Values Chart through substantial evidence of non-overlapping or synergistic effects on activities of daily living.[21][41]

Escobedo v. Marshalls (2005) 70 Cal.Comp.Cases 604 (WCAB en banc)

Binding en banc decision establishing that apportionment may be based on pre-existing pathology and asymptomatic conditions, subject to substantial medical evidence requirements.[9][57]

Matter of Schaan v. Jerry Thompson & Sons (2022) Cal. Wrk. Comp. P.D. LEXIS 264

Decision clarifying that psychiatric impairments arising from physical injuries cannot be considered in vocational rebuttal analysis unless exceptions to Labor Code Section 4660.1(c) apply.[56]

Matter of Kelly Havanis, ADJ3802146 (2024)

Recent panel decision addressing the burden of proof for rebutting the Combined Values Chart and the requirements for supplemental medical evidence.[8]

Appendix D: Forms and Documents Required in DEU Rating Process

DWC AD Form 101: Request for Summary Rating Determination

This form must be completed and submitted to the DEU to request a summary rating determination. The form requires identification of the claimant, claims administrator, medical issues to be rated, and the DEU office having jurisdiction.[2][2]

DWC AD Form 100: Employee's Disability Questionnaire

This form must be completed by the injured worker (with assistance from the claims administrator) and submitted with the rating request. The form provides important background information about the worker's pre-injury occupation, functional status, and post-injury condition.[2][2]

DWC AD Form 103: Request for Reconsideration of Summary Rating

This form must be completed and submitted within 30 days of receipt of the DEU rating if the worker or claims administrator wishes to request reconsideration. The form requires specification of the ground(s) for reconsideration.[14][40][43]

QME Form 111: Qualified Medical Evaluator's Findings Summary Form

This form is completed by the QME and accompanies the comprehensive medical evaluation report for unrepresented workers. The form requires the QME to summarize findings and conclusions regarding disputed medical issues.[37]

Appendix E: PDRS Tables and Calculation Examples

The 2005 Permanent Disability Rating Schedule includes detailed tables for:

Whole person impairment conversion tables for different body regions (spine, extremities, organs, etc.);

Diminished future earning capacity (FEC) adjustment factors for different injury categories (ranging from 1.1 to 1.4);

Occupational adjustment tables with modifiers A-J reflecting job demands;

Age adjustment tables reflecting the worker's age at the time of injury;

Combined Values Chart for combining multiple impairments.

All of these tables are available in the full 2005 PDRS document published by the DWC.[1][1][54]

Appendix F: San Francisco Bay Area Contact Information and Resources

Northern California DEU Office Division of Workers' Compensation Disability Evaluation Unit 1515 Clay Street, 5th Floor Oakland, CA 94612 Telephone: (510) 286-3700 or 1-800-794-6900

San Francisco WCAB 100 Montgomery Street, Suite 800 San Francisco, CA 94104

DWC Information & Assistance Unit 1-800-736-7401 Website: www.dir.ca.gov/dwc

San Francisco Workers' Compensation Self-Help Center Provides free information and assistance to self-represented injured workers Website: www.dir.ca.gov/dwc/landA.html

XIV. Comprehensive References and Bibliography

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Labor Code Section 4660.1 - Amended Schedule for Injuries on or After January 1, 2013

Labor Code Section 4061 - Determination of Permanent Disability

Labor Code Section 4062 - Medical Determination Disputes and QME Procedures

Labor Code Section 4062.1 - QME Procedures for Unrepresented Employees

Labor Code Section 4062.2 - QME Procedures for Represented Employees

Labor Code Section 4062.3 - Communications with QMEs

Labor Code Section 4628 - Requirements for Comprehensive Medical-Legal Evaluation Reports

Labor Code Section 4663 - Apportionment of Permanent Disability

Labor Code Section 4664 - Accumulation of Permanent Disability Awards

Labor Code Section 5814 - Penalties for Unreasonable Delay or Denial of Benefits

Labor Code Section 5813 - Sanctions and Attorney's Fees for Bad Faith

B. California Code of Regulations (Title 8)

Title 8 CCR Section 10 - Qualified Medical Evaluator Eligibility Requirements

Title 8 CCR Section 10160 - Summary Rating Determinations for Unrepresented Employees

Title 8 CCR Section 10160.1 - Summary Rating Determinations on Treating Physician Reports

Title 8 CCR Section 10161 - Summary Rating Determinations for Represented Employees

Title 8 CCR Section 10164 - Reconsideration of Summary Rating Determinations

Title 8 CCR Section 10166 - Consultative Rating Determinations

Title 8 CCR Section 30 - QME Panel Requests (Represented and Unrepresented)

Title 8 CCR Section 36 - Service of Comprehensive Medical-Legal Evaluation Reports

Title 8 CCR Section 38 - Medical Evaluation Time Frames and Extensions

Title 8 CCR Section 10605 - Mailbox Rule for Time Extensions

Title 8 CCR Section 10606 - Requirements for Comprehensive Medical-Legal Reports

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Vigil v. County of Kern (2024) En Banc Decision - Combined Values Chart Rebuttal Standards

Escobedo v. Marshalls (2005) 70 Cal.Comp.Cases 604 (WCAB en banc) - Apportionment to Preexisting Pathology

Matter of Schaan v. Jerry Thompson & Sons (2022) Cal. Wrk. Comp. P.D. LEXIS 264 - Psychiatric Impairment and Vocational Analysis

Rodriguez v. Continuing Life, LLC (2022) Cal. Wrk. Comp. P.D. LEXIS 304 - Mailbox Rule and QME Panel Strikes

Matter of Kelly Havanis, ADJ3802146 (2024) - Combined Values Chart and ADL Analysis

Athens Administrators v. WCAB (Kite) (2013) 78 Cal.Comp.Cases 213 - Addition of Impairments Instead of CVC

Nunes v. State of California (WCAB decisions) - Apportionment and Vocational Rebuttal

City of Petaluma v. WCAB (2019) 29 Cal.App.5th 1173 - "How and Why" Standard for Apportionment

D. DWC Publications and Forms

Schedule for Rating Permanent Disabilities (2005 Edition)

DWC Disability Evaluation Unit Homepage

DWC FAQs on the PDRS for Practitioners

DWC Qualified Medical Evaluator Database and Qualification Information

DWC Injured Worker Guidebook - Chapter 7: Permanent Disability Benefits

DWC Form 101: Request for Summary Rating Determination

DWC Form 100: Employee's Disability Questionnaire

DWC Form 103: Request for Reconsideration of Summary Rating

DWC Form 111: QME Findings Summary Form

E. Secondary Legal Sources and Practice Resources

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Sullivan on Comp - Vocational Evidence and LC 4660.1(c)

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DWC Administrative Director's Office - Organizational Chart

Conclusion: Synthesis of Key Findings and Strategic Recommendations

The California workers' compensation permanent disability rating system, as administered by the Division of Workers' Compensation's Disability Evaluation Unit, operates within a comprehensive statutory and regulatory framework designed to ensure consistent, objective assessment of work-related impairment and its impact on earning capacity. The system has evolved significantly since the enactment of Senate Bill 899 in 2004, particularly through the development of WCAB precedent requiring that the Permanent Disability Rating Schedule-while presumptively correct-remain rebuttable through substantial medical and vocational evidence demonstrating either that the scheduled rating does not accurately reflect the worker's actual diminished earning capacity or that procedural defects occurred in the rating process.

The DEU rater's function is primarily administrative: applying the PDRS methodology to the WPI rating assigned by the QME physician, adjusting for age and occupation, and considering

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