

California Workers' Compensation Settlement by Judicial Finding and Award: A Legal Analysis

(PART-A INJURED WORKERS ANALYSIS)

March 2, 2026

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CALIFORNIA WORKERS' COMPENSATION SETTLEMENT BY JUDICIAL FINDING AND AWARD

This report explains one of the main ways injured workers in California can receive benefits: through a Judicial Finding and Award (F&A). If you were hurt at work and cannot agree with your employer's insurance company on a fair settlement, a judge can decide your case and order the insurance company to pay you. This report covers how the process works, what benefits you can receive, how long it takes, and when an F&A may be the right choice for you.

Part 1: Understanding the Three Settlement Types

This section explains the three ways a California workers' compensation case can end, so you can understand where a Finding and Award fits in.

What Is a Finding and Award?

A Finding and Award (F&A) happens when a workers' compensation judge makes a final decision about your benefits after a hearing, because you and the insurance company could not agree on a settlement. The judge reviews your medical records, hears testimony, and decides how much you should receive in permanent disability benefits (money paid because your injury causes lasting physical limitations), temporary disability benefits (money paid while you recover and cannot work), and future medical care (ongoing treatment the insurance company must pay for). Under the F&A, your right to medical treatment continues, and you may reopen your claim within five years if your condition gets worse. Cal. Lab. Code §§ 5800–5814.5 (<https://www.legalfina.com/en/laws/ca/lab/4/4/6>); DWC Fact Sheet D (https://www.dir.ca.gov/dwc/factsheets/factsheet_d.pdf).

What Is a Compromise and Release?

A Compromise and Release (C&R) is a lump-sum settlement. You receive one payment, and the case closes permanently. The insurance company has no further responsibility—even if your condition worsens later. You must pay for all future medical care from the lump sum you received. A C&R gives you immediate money but removes your safety net. Alvandi Law Group, *Compromise & Release or Stipulated Findings & Award?* (<https://www.alvandigroup.com/blog/2022/january/compromise-release-or-stipulated-findings-award-/>).

What Is a Stipulation with Request for Award?

A Stipulation with Request for Award (Stip) is a middle option. You and the insurance company agree on a disability percentage and payment amount. Like an F&A, a Stip preserves your right to future medical care. Unlike an F&A, both sides must agree—a judge does not impose it. Payments come in periodic installments rather than one lump sum. Pacific Workers, *Comparing Stipulated Awards and Compromise and Release* (<https://www.pacificworkers.com/blog/2024/september/comparing-stipulated-awards-and-compromise-and-r/>).

Key Differences at a Glance

- F&A: Judge decides; future medical care preserved; can reopen claim within five years; payments over time.
- C&R: You and insurer agree; one lump sum; case permanently closed; no future medical care from insurer.
- Stip: You and insurer agree; future medical care preserved; payments over time; requires mutual consent.

Important: You do not have to accept a C&R or Stip. If the insurance company's offer is too low or your injury may worsen, you have the right to go to trial and let the judge decide through an F&A.

Part 2: The Legal Framework Behind F&A Awards

This section explains the laws and regulations that give judges the power to issue Findings and Awards.

Statutory Authority

California's workers' compensation system is created by Division 4 of the California Labor Code. This law establishes a trade-off: you receive guaranteed benefits without having to prove your employer was careless, and your employer is protected from personal injury lawsuits. Cal. Lab. Code § 5000 et seq. (<https://www.legalfina.com/en/laws/ca/lab/4/4/6>).

The authority for judges to issue F&A awards comes from several specific sections:

- Cal. Lab. Code § 5801 (<https://www.legalfina.com/en/laws/ca/lab/4/4/6>) allows the Workers' Compensation Appeals Board (WCAB) (the state agency that oversees workers' compensation disputes) to decide the total amount you are owed and the schedule for payments.
- Cal. Lab. Code § 5803 (<https://www.legalfina.com/en/laws/ca/lab/4/4/6>) allows the WCAB to change a previous decision if your disability increases within the reopening period.
- Cal. Lab. Code § 5814.5 (<https://www.legalfina.com/en/laws/ca/lab/4/4/6>) imposes penalties on insurance companies that unreasonably delay paying an award.
- Cal. Lab. Code § 5502 (<https://www.dir.ca.gov/t8/10759.html>) requires all cases to go through a mandatory settlement conference (a meeting where a judge helps both sides try to settle) before trial.

Regulatory Framework

The California Code of Regulations, Title 8 provides detailed procedural rules that implement the Labor Code:

- Cal. Code Regs. tit. 8, § 10759 (<https://www.dir.ca.gov/t8/10759.html>) establishes mandatory settlement conference procedures and requires parties to complete a Pre-Trial Conference Statement (a document listing all issues, witnesses, and exhibits for trial).
- Cal. Code Regs. tit. 8, § 10941 (<https://www.dir.ca.gov/wcab/WCABProposedRegulations/WCABRulesofPracticeandProcedure/WCABFinalCleanTextofRegs.docx>) gives workers' compensation judges "full power, jurisdiction and authority to hear and determine all issues of fact and law" and to issue final orders and awards.
- Cal. Code Regs. tit. 8, §§ 9792.20–9792.27 (<https://www.dir.ca.gov/dwc/mtus/mtus.html>) establish the Medical Treatment Utilization Schedule (MTUS), which sets the medical evidence standards for evaluating injuries and treatment.

Evidence Standards

The WCAB has established that an F&A must be supported by substantial evidence—evidence that a reasonable person would accept as adequate. You must prove your case by a preponderance of the evidence, meaning your position is "more likely than not" true (greater than 50% probable). Shouse Law Group, Findings and Award in California Workers' Compensation (<https://www.shouselaw.com/ca/workerscomp/trials/finding-and-award/>).

Part 3: Current Legal Landscape (March 2026)

This section covers recent changes and developments that affect F&A awards as of March 2026.

Recent Rate Changes

The Division of Workers' Compensation (DWC) announced updated benefit rates effective January 1, 2025, based on a 3.77588% increase in the State Average Weekly Wage (SAWW) (the statewide average of what workers earn per week, used to calculate benefit amounts):

- Temporary Total Disability (TTD) minimum rate: \$252.03 per week (up from \$242.86).
- TTD maximum rate: \$1,680.29 per week (up from \$1,619.15).
- Mileage reimbursement for travel to medical appointments: \$0.725 per mile.

These rates directly affect the amounts included in F&A awards. DWC Announces Temporary Total Disability Rates for 2025 (<https://www.dir.ca.gov/DIRNews/2024/2024-90.html>).

Permanent Disability Rating Rules

For injuries on or after January 1, 2013, judges must apply the 2005 Permanent Disability Rating Schedule (PDRS) with a 1.4 modifier to the whole person impairment percentage. This modifier replaced the older Future Earning Capacity (FEC) adjustment. DWC Workers' Compensation Benefits

(<https://www.dir.ca.gov/dwc/workerscompensationbenefits.htm>); DWC FAQs on the PDRS (https://www.dir.ca.gov/dwc/faq/deu_fa.html).

For injuries between January 1, 2005 and December 31, 2012, the 2005 PDRS applies with the FEC adjustment tables. For injuries before January 1, 2005, the 1997 PDRS applies. DWC FAQs on the PDRS (https://www.dir.ca.gov/dwc/faq/deu_fa.html).

Pending Regulatory Updates

The DWC scheduled a public hearing for February 27, 2026 to consider evidence-based updates to the Medical Treatment Utilization Schedule (MTUS) (<https://www.dir.ca.gov/dwc/mtus/mtus.html>). These updates may affect how doctors evaluate your injury and what treatments are approved. No major legislative changes to the F&A process are currently pending, so the existing rules remain stable through 2026.

Appeals and Court Review

If you disagree with a WCAB decision, you may petition the California Court of Appeal through a Petition for Writ of Review under Cal. Lab. Code §§ 5950 et seq. (https://www.dir.ca.gov/wcab/wcab_petitionforreconsideration.htm) The petition must be filed within 45 days of the final WCAB decision. The court uses a highly deferential standard—it will uphold the WCAB decision as long as substantial evidence supports it. This makes it difficult to overturn an F&A once issued, which is why building a strong case at the trial level is critical.

Part 4: The F&A Process Step by Step

This section walks you through the complete process from filing your claim to receiving your F&A award.

Step 1: File Your Claim

You start by giving your employer a DWC-1 claim form. This opens your workers' compensation case. Your employer must authorize medical treatment within one working day, with initial costs limited to \$10,000 while the claim is being investigated. The claims administrator (the insurance company or self-insured employer handling your claim) has 90 days to accept, deny, or investigate your claim. If they do not act within 90 days, the law presumes your injury happened at work. DWC FAQs for Employees (<https://www.dir.ca.gov/dwc/wcfaqiw.html>); DWC Workers' Compensation Benefits (<https://www.dir.ca.gov/dwc/workerscompensationbenefits.htm>).

Step 2: File an Application for Adjudication

If the claims administrator denies your claim or there are major disputes, you must file an Application for Adjudication of Claim with the WCAB. You have one year from the date of injury (or from the date of your last benefit payment, whichever is later) to file this application. Include the names of all parties, the date and description of your injury, the body parts injured, and any medical evidence you have. Laguna Law Firm, How Long Does It Take to Appeal a Denied Claim (<https://www.lagunalawfirm.com/how-long-does-it-take-to-appeal-a-denied-workers-compensation-claim-in-california/>); The Law Office of Cezar J. Torrez, The Appeals Process (<https://torrezlegal.com/blog/the-appeals-process-for-denied-workers-compensation-claims/>).

Step 3: Discovery and Evidence Gathering

After filing, both sides spend three to six months exchanging medical records, employment records, and other evidence. This process is called discovery. You may need to attend a deposition (a formal interview under oath where the other side's attorney asks you questions). Your deposition must be held within 100 miles of your home, and the insurance company must reimburse your lost wages and travel costs. Cal. Civ. Proc. Code § 2025.010 et seq. (<https://apexpi.com/e-learning-courses/depositions-and-discovery-strategic-use-in-fraud-defense-and-claim-resolution/>).

Step 4: Mandatory Settlement Conference

Your case must go through a Mandatory Settlement Conference (MSC) before trial, as required by Cal. Lab. Code § 5502 (<https://www.dir.ca.gov/t8/10759.html>) and Cal. Code Regs. tit. 8, § 10759 (<https://www.dir.ca.gov/t8/10759.html>). At the MSC:

- The judge meets privately with each side to discuss settlement value.
- The insurance company must bring a current printout of all benefits paid to you.
- Both sides must make a good-faith effort to settle.

- If you cannot settle, you and the other side complete a Pre-Trial Conference Statement listing all witnesses, exhibits, and issues for trial.

Step 5: Trial

If settlement fails, your case goes to trial. Workers' compensation trials differ from regular court:

- There is no jury. The judge decides everything.
- You present your case first, including your own testimony and medical evidence.
- The insurance company presents its case second.
- The standard of proof is preponderance of the evidence (more likely than not).

You must prove: (1) a work-related injury occurred, (2) the injury happened during your employment, and (3) the injury caused disability. Shouse Law Group, Findings and Award (<https://www.shouselaw.com/ca/workerscomp/trials/finding-and-award/>).

Step 6: The Judge Issues the F&A

The judge has 30 days after trial to issue a written decision. The F&A specifies whether an industrial injury occurred, which body parts were injured, your permanent disability percentage, the dollar amount of benefits, whether you receive future medical treatment, and whether you qualify for job retraining vouchers. Shouse Law Group, Findings and Award (<https://www.shouselaw.com/ca/workerscomp/trials/finding-and-award/>); Ford & Wallach, Findings and Award (<https://fordwallach.com/findings-and-award/>).

Part 5: Typical Timeline From Injury to F&A Award

This section provides realistic time estimates so you know what to expect.

General Timeline

The complete process from injury to final F&A award typically follows this schedule:

1. Claim filing and 90-day investigation period: 0–3 months
2. Denial, appeal, and Application for Adjudication filing: 3–6 months
3. Discovery and evidence gathering: 6–12 months
4. Mandatory Settlement Conference scheduling and attendance: 12–15 months
5. Trial setting and scheduling: 15–18 months
6. Trial and judge's written decision: 18–24 months

Laguna Law Firm, How Long Does It Take to Appeal (<https://www.lagunalawfirm.com/how-long-does-it-take-to-appeal-a-denied-workers-compensation-claim-in-california/>).

Factors That Affect Your Timeline

- Simple cases with clear liability and strong medical evidence may resolve in 12–18 months.
- Complex cases with multiple injuries, contested medical issues, or many witnesses can take 24–36 months.
- San Francisco WCAB experiences significant caseloads, which may add additional waiting time for trial dates.

Important: File your Application for Adjudication as soon as possible after a claim denial. Early filing preserves evidence and protects your rights.

Part 6: Medical Evidence and Permanent Disability Ratings

This section explains how doctors evaluate your injury and how the judge calculates your disability benefits.

Qualified Medical Evaluators

When you and the insurance company disagree about your disability, the claims administrator must refer you to a Qualified Medical Evaluator (QME)—a doctor specially certified by the DWC to evaluate workers' compensation injuries. You select one QME from a panel of three doctors provided by the DWC Medical Unit.

The QME examines you and writes a detailed report covering your condition, prognosis, disability percentage, and future medical needs. DWC QME Process (<https://www.dir.ca.gov/dwc/MedicalUnit/QualificationForQME.html>); DWC FAQs for Employees (<https://www.dir.ca.gov/dwc/wcfaqiw.html>).

Permanent and Stationary Status

Before the judge can determine your permanent disability, a doctor must declare you Permanent and Stationary (P&S), also called Maximum Medical Improvement (MMI). This means your medical condition has improved as much as it is going to. Once you are P&S, the doctor can assess how much lasting disability your injury caused. Until then, you continue receiving temporary disability benefits. DWC Fact Sheet D (https://www.dir.ca.gov/dwc/factsheets/factsheet_d.pdf); City and County of San Francisco, Workers' Compensation Terms (<https://www.sf.gov/workers-compensation-terms-and-definitions-for-injured-workers>).

How Your Disability Rating Is Calculated

For injuries on or after January 1, 2013, the judge follows these steps:

1. Determine your Whole Person Impairment (WPI) percentage using the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.
2. Apply the 1.4 modifier to the WPI percentage.
3. Adjust for your occupation and age using tables in the PDRS.
4. If multiple body parts are injured, combine the ratings following specific PDRS rules—each body region's impairment is adjusted separately before being combined with other regions.

DWC FAQs on the PDRS (https://www.dir.ca.gov/dwc/faq/deu_faq.html); Back to Basics: California Impairment-to-Disability Ratings (<https://hypersphere-bulldog-7lzs.squarespace.com/s/Back-to-Basics-Rating-a-California-Case-Using-the-AMA-Guides-5th-Edition-Revised-03-2024.pdf>).

Medical Treatment Utilization Schedule

The MTUS is the official set of medical guidelines used in California workers' compensation. Treatment that follows MTUS guidelines is presumed reasonable and necessary. If your doctor recommends treatment not covered by MTUS, the doctor must prove it is medically necessary. The MTUS is based on Evidence-Based Medicine (EBM) principles and draws primarily from the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines. Cal. Code Regs. tit. 8, § 9792.21 (<https://www.law.cornell.edu/regulations/california/8-CCR-9792.21>); DWC MTUS (<https://www.dir.ca.gov/dwc/mtus/mtus.html>).

Part 7: Appeals and Reconsideration

This section explains what happens if you or the insurance company disagrees with the judge's F&A decision.

Filing a Petition for Reconsideration

If you are unhappy with the F&A, you may file a Petition for Reconsideration with the WCAB. The deadline is 20 days after you receive the decision (25 days if served by mail within California; 30 days if served outside California). Sullivan & Crum, Time Extensions for Petitions for Reconsideration (<https://www.sullivanattorneys.com/blog/time-extensions-petitions-reconsideration>); WCAB Organization and Functions (https://www.dir.ca.gov/wcab/about_wcabf.htm).

Grounds for Reconsideration

You cannot file a petition simply because you disagree with the result. The law limits your reasons to:

- The judge acted beyond their authority.
- The decision was obtained through fraud.
- The evidence does not justify the decision.
- You have newly discovered evidence that you could not have presented at trial.
- The judge's findings of fact do not support the award.

Cal. Lab. Code § 5903 (https://www.dir.ca.gov/wcab/about_wcabf.htm).

What Happens After You File

- The judge has 15 days to prepare a report explaining the decision.
- During those 15 days, the judge may amend, modify, or rescind the decision.
- The WCAB must act on your petition within 60 days. If it does not act, your petition is automatically denied.
- If the WCAB grants your petition, it may order a new trial or modify the decision.

The Five-Year Reopening Rule

Separately from reconsideration, you can petition to reopen your F&A award if your condition worsens within five years of your date of injury. Under Cal. Lab. Code § 5803 (<https://www.legalfina.com/en/laws/ca/lab/4/4/6>), the WCAB can adjust your compensation based on changes in your disability—whether it has increased, decreased, returned, or resolved. This reopening right is one of the most valuable protections of an F&A compared to a C&R. Diefer Law Group, California Workers' Compensation 5-Year Rule Explained 2026 (<https://dieferlaw.com/blog/california-workers-compensation-5-year-rule/>); Serving Injured Workers, How to Reopen Workers' Comp (<https://servinginjuredworkers.com/blog/2024/10/how-to-get-more-medical-treatment-and-reopen-workers-comp/>).

Court of Appeal Review

If reconsideration is denied, you may petition the California Court of Appeal within 45 days of the final WCAB decision. The court applies a very deferential standard and will uphold the WCAB decision as long as substantial evidence supports it. Federal court review is limited to constitutional violations or federal law issues. Most F&A awards are never appealed. WCAB Petitions for Reconsideration (https://www.dir.ca.gov/wcab/wcab_petitionforreconsideration.htm).

Part 8: Future Medical Treatment and Additional Benefits

This section explains the ongoing benefits you receive under an F&A award beyond your disability payments.

Ongoing Medical Care

Under an F&A, the claims administrator must continue paying for all medically necessary treatment related to your work injury for as long as you need it. This includes doctor visits, surgery, physical therapy, prescription medications, and medical equipment. You do not bear the financial risk of unexpected medical needs—unlike a C&R, where all future care comes out of your lump sum. Ford & Wallach, Findings and Award (<https://fordwallach.com/findings-and-award/>); Invictus Law, Future Medical Treatment Under Workers' Compensation (<https://www.invictuslawpc.com/workers-compensation-lawyer/future-medical-treatment/>).

Important: Treatment must be reasonable and necessary under the MTUS guidelines. If your doctor recommends treatment outside MTUS guidelines, the doctor must prove medical necessity. The insurance company may request utilization review (UR), and if UR denies treatment, you can challenge the denial through independent medical review (IMR). DWC FAQs for Employees (<https://www.dir.ca.gov/dwc/wcfaqiw.html>).

Supplemental Job Displacement Benefit Vouchers

If you have permanent partial disability and cannot return to your pre-injury job, you may qualify for a Supplemental Job Displacement Benefit (SJDB) voucher. This voucher provides funding for job retraining, education, tuition, and books at accredited schools. Eligibility requires: (1) permanent partial disability, (2) inability to return to your pre-injury job at similar wages, and (3) your employer's failure to offer suitable alternative work within the required time. Sullivan & Crum, Liability for the Supplemental Job Displacement Benefit (<https://www.sullivanoncomp.com/blog/liability-for-the-supplemental-job-displacement-benefit/>); Phoenix Workers' Compensation Attorneys, Exploring Additional Benefits (<https://injuredworker.com/workers-compensation/beyond-the-basics-exploring-additional-workers-compensation-benefits/>).

Temporary Disability Benefits

If you have not returned to full-duty work at the time of the F&A, the judge may order continued temporary disability (TD) payments. TD pays two-thirds of your gross pre-injury wages, up to the 2025 maximum of \$1,680.29 per week. The minimum rate is \$252.03 per week. You receive these payments every two weeks. DWC Temporary Disability Benefits (<https://www.dir.ca.gov/dwc/TemporaryDisability.htm>); DWC 2025 TTD Rates (<https://www.dir.ca.gov/DIRNews/2024/2024-90.html>).

Mileage and Out-of-Pocket Reimbursement

You are entitled to reimbursement for travel to medical appointments at \$0.725 per mile (2025 rate), plus parking and bridge tolls. If you paid out of pocket for medically necessary treatment the insurance company should have covered, you may seek reimbursement through the F&A award. DWC Workers' Compensation Benefits (<https://www.dir.ca.gov/dwc/workerscompensationbenefits.htm>).

Part 9: Liens, Costs, and Financial Considerations

This section explains how other claims against your award work and what your benefits may look like in dollar terms.

Health Care Provider Liens

Doctors, hospitals, and other medical providers who treated you may file lien claims against your workers' compensation award. A lien is a legal right to be paid from your benefits before you receive your share. These liens are filed under Cal. Lab. Code § 4900 et seq. (<https://www.advocatemagazine.com/article/2019-march/workers-compensation-liens-and-credit-issues>) and must comply with Cal. Code Regs. tit. 8, § 10862 (<https://www.dir.ca.gov/t8/10862.html>). The judge determines the validity and amount of all liens in the F&A.

Employer Subrogation Rights

If you receive workers' compensation benefits and also recover money from a third party who caused your injury (for example, a negligent driver), your employer has a subrogation right—a legal claim to be repaid from your third-party recovery. Under Cal. Lab. Code § 3852 (<https://www.advocatemagazine.com/article/2019-march/workers-compensation-liens-and-credit-issues>), the employer's lien equals the total workers' compensation benefits paid. After paying your attorney's fees and litigation costs, the employer's lien is satisfied before you receive the remaining balance.

How Permanent Disability Benefits Are Calculated

Your permanent disability award depends on three factors:

- Your permanent disability percentage (determined by the judge based on medical evidence and the PDRS).
- Your average weekly wages at the time of injury.
- Your date of injury (which determines which rating schedule applies).

The formula is: Disability Percentage × Number of Weeks (from the PDRS table) × Weekly Rate = Total Award. Occupational and age modifiers may increase or decrease this amount. DWC Fact Sheet D (<https://www.dir.ca.gov/dwc/factsheets/factsheetd.pdf>); DWC FAQs on the PDRS (<https://www.dir.ca.gov/dwc/faq/deufaq.html>).

Research shows approximately 55% of California settlements fall between \$2,000 and \$20,000, and 13% fall between \$20,001 and \$40,000. Invictus Law, Future Medical Treatment (<https://www.invictuslawpc.com/workers-compensation-lawyer/future-medical-treatment/>).

Attorney's Fees

If you have a lawyer, the attorney's fee is generally 10% to 15% of the additional benefits obtained through representation, as set by Cal. Lab. Code § 5307 (<https://www.shouselaw.com/ca/workerscomp/trials/finding-and-award/>). The judge approves the fee amount in the F&A award. Your attorney also recovers reasonable costs such as deposition fees, expert witness fees, and records acquisition costs. These amounts are deducted from your award.

Part 10: When to Choose an F&A Over Other Settlements

This section helps you decide whether an F&A is the right strategy for your situation.

Choose an F&A When:

- Your medical condition is unstable or may worsen over time.
- Your future medical needs cannot be reliably predicted right now.

- You are young with many working years ahead, making long-term earning capacity reductions significant.
- Your occupation or age substantially affects your disability rating under the PDRS.
- The insurance company's settlement offers seem significantly below fair value.
- You have a progressive condition such as degenerative spinal disease, repetitive strain injury, occupational disease, or psychological injury.

The F&A preserves your five-year right to reopen and your lifetime right to medical care—protections that are invaluable when your injury's long-term consequences are uncertain. Alvandi Law Group (<https://www.alvandigroup.com/blog/2022/january/compromise-release-or-stipulated-findings-award/>); Invictus Law (<https://www.invictuslawpc.com/workers-compensation-lawyer/future-medical-treatment/>).

Consider a C&R or Stip When:

- Your injury has clearly stabilized and your medical prognosis is positive.
- You have returned to work at comparable or better wages.
- Future medical treatment needs appear minimal or unlikely.
- You value immediate financial control and certainty over long-term coverage.
- You plan to move outside California, where ongoing California workers' compensation medical coverage becomes complicated.

Important Protections for All Workers

Critical: Workers' compensation benefits are available to all injured employees regardless of immigration status. You have the right to file a claim, receive medical treatment, and obtain an F&A award whether you are a U.S. citizen, permanent resident, or undocumented worker. California EDD, Benefits and Resources for Undocumented Workers (https://edd.ca.gov/en/disability/undocumented_workers/).

San Francisco WCAB Information

If your case is in the San Francisco area, the WCAB office locations include:

- 455 Golden Gate Avenue, 9th Floor, San Francisco, CA 94102
- 100 Montgomery Street, Suite 800, San Francisco, CA 94104
- 630 Sansome Street, 4th Floor, Room 475, San Francisco, CA 94111
- 1855 Gateway Boulevard, Suite 850, Concord, CA 94520

WCAB Locations (<https://www.dir.ca.gov/wcab/wcab.htm>).

San Francisco judges expect thorough preparation. Come to your Mandatory Settlement Conference with complete medical evidence, proper Pre-Trial Conference Statements, and all exhibits clearly identified by author, date, and type as required by Cal. Code Regs. tit. 8, § 10759 (<https://www.dir.ca.gov/t8/10759.html>).

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13. WCAB Rules of Practice and Procedure – Final Clean Text (<https://www.dir.ca.gov/wcab/WCABProposedRegulations/WCABRulesofPracticeandProcedure/WCABFinalCleanTextofRegs.docx>) - California Department of Industrial Relations.
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California Workers' Compensation Settlement by Judicial Finding and Award: A Legal Analysis

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

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

March 2, 2026

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California Workers' Compensation Settlement by Judicial Finding and Award: A Comprehensive Legal Analysis

Generated by: Legal AI Assistant | Facilitated by: The Law Offices of Fernando Hidalgo, Inc. | Date: March 2, 2026

Executive Summary

A Judicial Finding and Award (F&A) represents one of three primary settlement mechanisms available to injured workers in California's workers' compensation system, alongside Compromise and Release (C&R) agreements and Stipulations with Request for Award (Stips)[3][5][8]. An F&A occurs when a workers' compensation administrative law judge makes a final determination regarding permanent disability benefits, temporary disability benefits, future medical care, and other compensation entitlements after a contested hearing, because the parties have been unable to reach a negotiated settlement[3][29]. Unlike lump-sum settlements that terminate future liability, an F&A preserves the injured worker's right to ongoing medical treatment and periodic payments, creating a structured long-term benefit stream[3][5][16].

The timeline for achieving final resolution through an F&A typically ranges from six months to two years or longer, depending on injury complexity, dispute intensity, and whether reconsideration petitions are filed[23]. Cases without significant disputes may resolve within six to nine months, while cases with moderate to severe injuries or substantial disagreements between parties frequently require twelve to eighteen months to reach trial[23]. The process involves mandatory settlement conferences before trial, comprehensive medical evidence presentation, testimony from witnesses and medical professionals, and issuance of a written decision within thirty days of trial conclusion[3][29][31][32].

An F&A differs materially from other settlement types in its permanence, flexibility, and ongoing benefit structure. While a C&R provides a single lump-sum payment that completely closes the claim with no further liability, an F&A preserves lifetime medical care entitlement and allows for claim reopening within five years if the injured worker's condition worsens[3][5][21][24]. An injured worker should select an F&A settlement approach when the injury's long-term medical trajectory remains uncertain, when the worker's disability may increase over time, or when permanent total disability status becomes possible[3][8][16]. Conversely, workers with stable, well-understood injuries who prioritize immediate financial control and certainty may prefer a C&R or Stip arrangement[5][8].

The strategic value of pursuing an F&A rather than settling earlier depends on several qualitative factors: the strength of medical evidence supporting disability claims, the reliability of the treating physician's prognosis, the worker's age and occupational factors affecting future earning capacity, and the likelihood that the workers' compensation insurance carrier will offer fair value at mandatory settlement conference[8][23]. Medium-confidence assessment applies to most F&A outcomes, as the judicial determination provides certainty regarding compensation amounts but introduces appellate risk if either party contests the decision through petition for reconsideration or writ of review[23][31][32].

Legal Framework

Statutory Authority for Findings and Awards

The California workers' compensation system derives its fundamental authority from the California Labor Code, Division 4, which establishes the comprehensive statutory framework governing occupational injury compensation[1][7][11]. Labor Code Section 5000 et sequentia creates the entire workers' compensation system as a quid pro quo arrangement where injured workers receive guaranteed benefits without proving employer negligence, while employers receive immunity from civil litigation[11]. The statutory basis for judicial findings and awards specifically appears in Labor Code Sections 5800 through 5814.5, which establish the Appeals Board's authority to issue final decisions on workers' compensation matters[11].

Labor Code Section 5801 specifically authorizes the Appeals Board to "decide the total amount of compensation due to an employee and to whom it shall be paid and the periods during which payment shall be made"[11]. This provision gives the WCAB comprehensive power to determine all aspects of workers' compensation entitlements when parties do not reach settlement. Labor Code Section 5803 permits the Appeals Board to revisit and modify previous decisions if the injured worker demonstrates increased disability within the statutory reopening period, creating the mechanism through which F&A awards can be adjusted

upon petition to reopen[11][21][24]. Labor Code Section 5814.5 establishes penalties for unreasonable delays in paying compensation after an award is issued, incentivizing insurance companies to pay F&A awards promptly[11].

The procedural framework governing how judges issue findings and awards appears in Labor Code Section 5502, which requires all workers' compensation cases to proceed through a mandatory settlement conference before trial[6][9]. Labor Code Section 5700 grants workers' compensation judges the authority to hear all issues of fact and law in contested cases and to "issue any interim, interlocutory and final orders, findings, decisions and awards as may be necessary to the full adjudication of the case"[14]. These statutory provisions collectively establish both the substantive entitlement to F&A awards and the procedural mechanisms through which they are awarded.

Regulatory Framework

The California Code of Regulations, Title 8, implements the Labor Code's statutory provisions through detailed procedural rules. Title 8, California Code of Regulations Section 10759 establishes the mandatory settlement conference procedures that precede any finding and award[6]. This regulation specifies that "the workers' compensation judge shall have authority to inquire into the adequacy and completeness, including provision for lien claims, of Compromise and Release agreements or Stipulations with Request for Award or orders, and to issue orders approving Compromise and Release agreements or awards or orders based upon approved stipulations"[6]. The regulation further requires that parties "complete a joint Pre-Trial Conference Statement setting forth the issues and stipulations for trial, witnesses, and a list of exhibits by the close of the mandatory settlement conference"[6].

Title 8, California Code of Regulations Section 10353 grants settlement conference authority to workers' compensation judges, permitting them to inquire into the adequacy of settlements, approve agreements, and issue orders[14]. Section 10941 establishes the scope of a workers' compensation judge's authority to conduct trials and issue findings and awards, providing that "a workers' compensation judge shall have full power, jurisdiction and authority to hear and determine all issues of fact and law presented and to issue any interim, interlocutory and final orders, findings, decisions and awards as may be necessary to the full adjudication of the case"[14]. These regulatory provisions create the procedural infrastructure through which F&A awards are issued.

The permanent disability rating regulatory framework appears in Title 8, California Code of Regulations Sections 9792.20 through 9792.27, which establish the Medical Treatment Utilization Schedule (MTUS)[38][40]. This schedule provides the medical evidence standards by which treating physicians, qualified medical evaluators, and workers' compensation judges assess the extent of permanent impairment and resulting disability[38][40]. For injuries occurring on or after January 1, 2013, the regulations require application of a 1.4 modifier to whole person impairment, replacing the former Future Earning Capacity adjustment tables[2][10][17].

Key Case Law and BIA Precedent

While the Board of Immigration Appeals (BIA) precedent does not apply to workers' compensation matters, the California Workers' Compensation Appeals Board has established extensive precedent governing F&A awards. En banc decisions of the WCAB constitute binding precedent on all panels and workers' compensation judges under the principle of stare decisis[26]. Recent en banc decisions have addressed procedural requirements for electronic witness testimony, validity of replacement qualified medical evaluator panels, and clerical error correction in awards[26].

The WCAB has established that a Finding and Award must be supported by "substantial evidence," defined as evidence that is reasonable, credible, and of solid value—evidence that a reasonable person might accept[29]. This evidentiary standard requires that parties prove their positions "by a preponderance of the evidence," meaning "more likely than not"[29][35]. The substantial evidence standard differs from the clear and convincing standard applied in some civil matters and remains the controlling burden of proof in workers' compensation cases[29][37].

Case law establishing the distinction between findings and awards and other settlement mechanisms is substantial. In comparisons with Compromise and Release agreements, the courts have established that F&As preserve future medical care entitlements, allow for claim modification within five years of injury, and create

ongoing payment obligations for the employer or insurance carrier[3][5][8][16][21][24]. The distinction proves critical for injured workers with progressive conditions, unpredictable injuries, or age and occupational factors suggesting continued disability development[5][8][16].

Policy Guidance and Administrative Direction

The Division of Workers' Compensation (DWC) has issued extensive guidance addressing F&A awards, permanent disability calculations, and related benefits. DWC fact sheet D addresses permanent disability benefits and explicitly describes the F&A process, noting that judges' findings constitute formal evidence when rating permanent disability, and that "a judge's finding is called a F&A" that "generally consists of a sum of money and a provision for the claims administrator to pay for approved future medical treatment"[10][18]. This guidance confirms that F&As create ongoing medical care obligations distinct from lump-sum C&R settlements.

The DWC has also issued guidance on the 1.4 modifier for permanent disability calculations in injuries occurring after January 1, 2013, clarifying that this adjustment replaces the former Future Earning Capacity evaluation[7][10][17][36]. For injuries occurring between January 1, 2005 and December 31, 2012, the DWC has established that the 2005 Permanent Disability Rating Schedule applies with specific modifiers for occupation, age, and regional impairment combinations[2][13].

Current Legal Landscape: March 2026

Recent Developments in Findings and Awards

The California workers' compensation system continues to evolve through regulatory amendments and board decisions affecting F&A awards. As of March 2026, the system operates under the permanent disability rating modifications adopted through Labor Code amendments effective January 1, 2013, which established the 1.4 modifier replacing the previous Future Earning Capacity adjustment approach[7][17][36]. These modifications remain the controlling law for all injuries on or after that effective date and significantly impact the monetary amounts included in F&A awards[7][17].

Recent WCAB decisions have reinforced strict compliance requirements for procedural rules governing F&A awards. The WCAB has emphasized that parties must properly identify all insurance carriers, employers, and representatives in pleadings, and that failure to meet procedural requirements can result in dismissal or non-recognition of documents[26]. These decisions underscore the importance of precise procedural compliance when pursuing F&A awards through the WCAB.

The 2025 temporary total disability rates announced by the DWC in October 2024 have become effective January 1, 2025, increasing minimum TTD rates from \$242.86 to \$252.03 per week and maximum rates from \$1,619.15 to \$1,680.29 per week[36]. These adjustments, based on the State Average Weekly Wage (SAWW) increase of 3.77588%, directly affect the compensation amounts included in F&A awards for workers currently in temporary disability status or for historical TTD calculations[36]. The SAWW adjustments also affect permanent total disability and life pension benefit calculations[36].

Ninth Circuit and California Court of Appeal Considerations

Although workers' compensation appeals typically proceed through state WCAB reconsideration procedures and then to the California Court of Appeal via writ of review under Labor Code Section 5950 et sequentia, federal constitutional issues occasionally reach federal courts[15]. The Ninth Circuit has limited jurisdiction over state workers' compensation matters, with federal review generally restricted to constitutional due process challenges, federal question jurisdiction, or civil rights violations[15]. Northern California practitioners should note that writ of review petitions to the Court of Appeal must be filed within forty-five days of the final WCAB decision[15].

The appellate standard for reviewing WCAB findings and awards in the Court of Appeal requires demonstration that the board lacked jurisdiction, acted in excess of its powers, or rendered decisions unsupported by substantial evidence[15][32]. This deferential appellate standard makes it difficult to overturn F&A awards once issued, emphasizing the importance of developing strong evidence and testimony at the trial level to create an adequate appellate record[15].

Pending Regulatory and Legislative Developments

The DWC has initiated notice of public hearing for February 27, 2026 regarding proposed evidence-based updates and adoptions to the Medical Treatment Utilization Schedule (MTUS), which will affect the medical evidence standards for treating physicians and medical evaluators in worker compensation cases[38]. These anticipated updates will influence the medical evidence presented in F&A cases and may affect how treating physicians establish permanent and stationary status—a critical threshold for F&A determinations[38].

No immediate legislative changes appear pending that would fundamentally alter the F&A award process or settlement framework, though ongoing legislative attention to workers' compensation permanence ratings and medical treatment standards remains active in the California legislature[36]. The stability of the current F&A statutory and regulatory framework suggests that practitioners can rely on existing procedures through 2026 with reasonable confidence[36].

San Francisco-Specific Context: WCAB and Local Practice

San Francisco Immigration Court and Workers' Compensation Appeals Board Locations

The error in the preceding section title reflects a critical clarification: this research addresses California workers' compensation law, not immigration law. The Workers' Compensation Appeals Board in the San Francisco district operates from multiple locations throughout the Bay Area[1][15]. The Appeals Board's primary address is located at 455 Golden Gate Avenue, 9th Floor, San Francisco, California 94102[15]. For San Francisco workers' compensation disputes, the local WCAB district office addresses include 100 Montgomery Street, Suite 800, San Francisco, CA 94104, and 630 Sansome Street, 4th Floor, Room 475, San Francisco, CA 94111[15]. A satellite location serves the Concord area at 1855 Gateway Boulevard, Suite 850, Concord, CA 94520[15].

San Francisco WCAB Judge-Specific Practices and Preferences

While the search results do not contain specific information regarding individual San Francisco workers' compensation judges' preferences regarding F&A awards versus other settlement types, practitioners in the San Francisco WCAB commonly observe that judges encourage good-faith settlement negotiations during mandatory settlement conferences before proceeding to trial[9][23]. The San Francisco WCAB operates with substantial case congestion, and judges generally favor efficient resolution through settlement when possible, though they will proceed to trial if parties cannot reach agreement[9].

San Francisco WCAB judges typically require comprehensive medical evidence before trial and expect parties to complete discovery during the mandatory settlement conference phase[6][9][14][42]. Failure to present complete medical evidence or to properly identify all parties and insurance carriers can result in sanctions, delays, or adverse rulings[14][26]. San Francisco practitioners have observed that judges in this district expect detailed Pre-Trial Conference Statements complying with WCAB Rule 10759 requirements, with clear identification of all exhibits and witnesses[6][9].

Mandatory Settlement Conference Procedures in San Francisco

California Labor Code Section 5502 requires all workers' compensation cases to proceed through a mandatory settlement conference before trial[6][9]. In the San Francisco WCAB, mandatory settlement conferences typically involve separate caucuses where the judge meets privately with each party and their counsel to discuss settlement value and explore compromise[9]. During these conferences, the disability evaluation unit (DEU), a state agency that provides expert permanent disability ratings, may provide rating opinions if the parties request guidance regarding disability rating disputes[9][10].

The San Francisco WCAB requires that attorneys and insurance representatives come to mandatory settlement conferences fully prepared to negotiate, with current benefit payment records available for inspection[6][9]. The court expects all parties to make good-faith efforts to settle, and judges in this district will often encourage continued settlement discussions before setting cases for trial[9]. If settlement is not reached, the judge requires completion of the Pre-Trial Conference Statement specifying all witnesses, exhibits, and issues for trial[6][9].

San Francisco Bay Area Workers' Compensation Insurance Carriers and Defense Practices

The San Francisco Bay Area includes headquarters and major offices for numerous national and regional insurance carriers serving the workers' compensation market[17]. Insurance carriers operating in Northern

California vary widely in their settlement practices regarding F&A awards versus other resolution mechanisms. Some carriers prefer F&A awards because they establish definitive liability and appeal rights, while others favor C&R settlements for finality and closure[5][8][19].

The Bay Area's diverse economy includes significant technology sector employment (with corresponding carpal tunnel and ergonomic injuries), construction and building trades, healthcare and nursing home employment, transportation and delivery services, and agricultural work in nearby regions[7][17][18]. These varied industries produce different injury patterns affecting settlement strategies-technology workers with progressive conditions may benefit more from F&A awards preserving future medical care, while acute construction injuries may resolve more efficiently through C&R agreements[5][8][16].

The Findings and Award Process: Comprehensive Procedural Analysis

Initial Claim Filing and Administrative Requirements

The workers' compensation process begins when an injured employee provides a claim form (Form DWC-1) to their employer[18]. This filing opens the workers' compensation case and triggers the employer's obligation to authorize medical treatment within one working day, with initial treatment costs limited to \$10,000 while the claim investigates[7][18]. The claims administrator (insurance company or self-insured employer) must accept, deny, or provide notice that the claim is pending investigation within ninety days of receiving the completed claim form[7][10][18]. If the claims administrator does not act within ninety days, a statutory presumption applies that the injury arose out of and in the course of employment[10].

The injured worker's right to proceed toward a Finding and Award depends on the claims administrator's acceptance of the claim. If the claims administrator denies the claim, the injured worker must file an Application for Adjudication of Claim with the WCAB within one year of the date of injury (or within one year of the date of last payment of benefits, whichever is later)[12][23]. This filing initiates formal proceedings that may ultimately result in a F&A award if the case reaches trial[12][23].

Mandatory Settlement Conference and Required Documentation

After an Application for Adjudication is filed, WCAB rules require the case to proceed through a Mandatory Settlement Conference (MSC) before trial[6][9]. Labor Code Section 5502 and WCAB Rule 10759 establish the MSC procedures[6][9]. At the MSC, the worker's attorney and the insurance company representative must appear and make good-faith efforts to settle the case[6][9]. Both parties must meet and confer before the MSC and prepare a joint Pre-Trial Conference Statement setting forth all issues, stipulations, witnesses, and exhibits by the close of the conference[6].

The Pre-Trial Conference Statement must clearly identify each exhibit "by author/provider, date, and title or type," with specific rules for combining documents[6]. Medical reports from different authors or dates must be listed separately, except that EOB letters, excerpted physician records, and excerpted business records may be combined under specific conditions[6]. Failure to comply with these documentation requirements can result in exhibits being excluded from evidence at trial[6][42].

The insurance company must have available at the MSC "a current computer printout of benefits paid" for the worker's inspection[6]. This requirement ensures both parties have identical information regarding temporary disability payments, medical treatment costs, mileage reimbursements, and other benefits paid to date[6][7]. If the parties cannot agree on the permanent disability rating based on available medical evidence, the judge may order the Disability Evaluation Unit (DEU) to provide an expert rating opinion to assist settlement negotiations[2][9].

Declaration of Readiness and Trial Setting

If parties cannot reach settlement at the MSC, either party files a Declaration of Readiness to Proceed with trial[42]. This declaration triggers the requirement that the filing party immediately submit all medical reports from treating physicians, qualified medical evaluators, or agreed medical evaluators that are in its possession and relevant to the issues being tried[42]. All exhibits must be filed with the declaration or by specified deadlines, as failure to file exhibits timely can result in waiver of the right to present them at trial[6][42].

The WCAB must set the case for trial within a specified timeframe after the Declaration of Readiness is filed, typically 30 to 120 days from filing (with actual scheduling often requiring 60 to 90 days in the San Francisco

district)[23][42]. Cases without significant medical disputes or complex issues may be assigned to expedited hearings, where the judge conducts a brief trial focused on specific issues[42]. Most cases involving permanent disability determinations proceed to standard trials where both parties present full evidence and witness testimony[29][42].

Trial Procedure and Evidence Presentation

Workers' compensation trials at the WCAB differ substantially from civil court trials[3][29]. No jury participates; the judge serves as both fact-finder and decision-maker[3][29]. The applicant (injured worker) typically presents evidence first, including testimony from the worker themselves, testimony from treating physicians or medical evaluators, documentary evidence of wages and work capacity, and any other evidence supporting the claim[29][42].

The defense presents evidence after the applicant, including testimony from the insurance company's medical evaluator, defense witnesses, employment records, and other evidence supporting the carrier's position[29][39][42]. The judge has authority to conduct discovery during trial, including depositions of physicians and other witnesses if not previously completed[39][42]. Depositions in workers' compensation cases are governed by California Code of Civil Procedure Sections 2025.010 et sequentia, with specific protections for injured workers regarding deposition location and expense reimbursement[39].

The standard of proof at trial is "preponderance of the evidence," meaning the party's evidence must show that its position is "more likely than not" or greater than 50 percent probable[29][35]. The applicant bears the burden of proving: (1) a work-related injury occurred, (2) the injury arose out of and in the course of employment, and (3) the injury resulted in disability[29]. Once the applicant establishes these elements, the burden shifts to the defense to prove affirmative defenses such as independent contractor status, statute of limitations defenses, or lack of causal relationship[29].

Judicial Determination and Issuance of the F&A

After trial concludes, the judge has thirty days to issue a written Finding and Award decision[29][31]. The decision must include findings of fact addressing all major issues litigated, legal conclusions applying workers' compensation law to those facts, and an award specifying: (1) whether an industrial injury is found, (2) the body parts injured, (3) the permanent disability percentage if applicable, (4) the monetary amount of permanent disability benefits based on the date of injury and average weekly wages, (5) the duration and amount of temporary disability paid, (6) whether future medical treatment will be provided, (7) whether the worker is entitled to supplemental job displacement benefits, and (8) any other relief awarded[3][10][29].

The F&A becomes final upon issuance unless a party files a Petition for Reconsideration within twenty days of service (or twenty-five days if service occurred by mail within California)[31][32]. The judge's decision is based solely on evidence presented at trial-no new evidence can be introduced after trial except through petition for reconsideration based on newly discovered evidence that could not have been produced at hearing[32].

Comparison with Other Settlement Types and Strategic Selection

Compromise and Release: Lump-Sum Finality

A Compromise and Release (C&R) agreement represents a fundamentally different settlement approach from a Finding and Award[3][5][8][19]. In a C&R, the injured worker receives a single lump-sum payment, typically representing the estimated present value of all future benefits to which the worker would be entitled[5][8][19]. Once the judge approves the C&R and the worker receives payment, the case is completely closed-the employer has no further liability, and the worker cannot seek additional compensation regardless of subsequent medical needs or disability worsening[3][5][8][19].

The C&R provides immediate financial relief and allows the worker to control how settlement funds are used[5][8]. Insurance companies often prefer C&Rs because they eliminate future liability and provide certainty regarding total cost exposure[5][8][19]. However, C&R settlements create substantial risk for workers whose injuries may worsen or whose medical needs were underestimated at settlement[5][8][16][19]. If a worker's condition deteriorates significantly after C&R approval, the worker must pay for all future medical care from the lump-sum settlement amount received[5][8][16][19].

Research on settlement patterns shows that approximately 55% of California workers' compensation settlements fall between \$2,000 and \$20,000, with 13% between \$20,001 and \$40,000, and smaller percentages in higher ranges[16]. These lump-sum amounts may seem substantial initially but may prove inadequate if serious future medical needs emerge[5][8][16][19]. For workers with progressive conditions such as chronic pain, degenerative joint disease, or psychological injury patterns, C&R settlements create dangerous long-term risk[5][8][16].

Stipulation with Request for Award: Hybrid Approach

A Stipulation with Request for Award (Stip) settlement represents a compromise between F&A awards and C&R agreements[8][10][18]. In a Stip, the worker and insurance company mutually agree on a specific permanent disability percentage, temporary disability calculation, and monetary award, but the settlement preserves the worker's right to future medical treatment related to the industrial injury[8][10][18]. Unlike a C&R where the worker receives all money immediately, Stip awards typically involve periodic payments spread across a fixed number of weeks based on the disability percentage[8][10][18].

A Stip settlement requires judge approval of the agreement to ensure adequacy and fairness to the worker[6][8][10][29]. The judge inquires into the completeness of the settlement, including whether all proper parties are bound, whether liens have been addressed, and whether the settlement amount is reasonable[6][29]. If the judge approves the Stip, it becomes a binding award with the same effect as a F&A regarding future medical care entitlement[8][10][18].

Stip settlements prove advantageous for workers whose medical conditions have stabilized and whose long-term medical needs are predictable and modest[8][10][18]. They provide greater certainty than F&A awards (since medical disputes have been resolved through agreement rather than litigation) while maintaining ongoing medical care coverage superior to C&R settlements[8][10][18]. However, Stips require both parties' agreement, so they cannot be imposed unilaterally if the insurance carrier refuses to settle[8].

Strategic Selection Framework: When F&A Awards Are Optimal

Injured workers should pursue F&A awards rather than settling through C&R or Stip when several factors converge: (1) the worker's medical condition remains unstable or subject to significant ongoing development, (2) future medical needs cannot be reliably predicted with current medical information, (3) the worker is young with many working years remaining (making long-term earning capacity reductions significant), (4) the worker's occupation or age substantially affects permanent disability ratings under the PDRS, or (5) the insurance carrier's settlement offers appear significantly below fair value[5][8][16][23].

For workers with progressive injuries such as degenerative spinal conditions, repetitive strain injuries with cumulative effects, occupational diseases with delayed manifestation, or psychological injuries developing over time, F&A awards provide critical protection by preserving the right to reopen claims within five years if disability worsens[3][5][21][24]. The five-year reopening window allows injured workers to petition for additional benefits if new medical evidence demonstrates condition deterioration[21][24]. This protection proves invaluable when an injury's long-term consequences remain uncertain[21][24].

Conversely, workers should consider C&R or Stip settlements when: (1) the injury has stabilized and medical prognosis is clear and positive, (2) the injured worker has returned to work at comparable wages or better, (3) future medical treatment needs appear minimal or unlikely, (4) the worker values financial certainty over long-term medical coverage, or (5) the worker intends to relocate outside California (where ongoing California workers' compensation medical care coverage becomes complicated)[5][8][19]. Additionally, workers in financial distress requiring immediate funds may find C&R settlements attractive despite increased long-term risk[5][8][19].

Medical Evidence Standards and Permanent Disability Determination

Qualified Medical Evaluators and Disability Rating Process

The determination of permanent disability in F&A awards depends critically on medical evidence[10][18][41]. When the injured worker and insurance company disagree about permanent disability status, the claims administrator must refer the worker to a Qualified Medical Evaluator (QME) selected from a panel of three physicians provided by the DWC Medical Unit[10][18][41]. The QME examines the worker

and prepares a comprehensive medical-legal report addressing the worker's condition, prognosis, permanent and stationary status, percentage of permanent disability, and future medical treatment needs[10][18][41].

QMEs must meet specific educational and licensing requirements, pass qualifying examinations, and participate in ongoing continuing education on the workers' compensation evaluation process[10][18][41]. This credentialing process ensures QME reports provide reliable medical evidence for F&A determinations[10][18][41]. The QME report typically serves as the primary medical evidence in F&A trials, though the judge may also consider treating physician reports, agreed medical evaluator reports, or the applicant's own medical evidence[29][42].

The judge must determine whether the injured worker has reached "Permanent and Stationary" (P&S) or "Maximal Medical Improvement" (MMI) status before issuing a Finding and Award regarding permanent disability[10][18][20]. P&S status means "your medical condition has reached maximum medical improvement. Once you are P&S, a doctor can assess how much, if any, permanent disability resulted from your work injury"[10][18][20]. Until a treating physician or medical evaluator declares the worker P&S, the judge cannot make a permanent disability finding and the worker remains entitled to continuing temporary disability benefits[10][18][43].

Application of Permanent Disability Rating Schedule

For injuries occurring on or after January 1, 2013, workers' compensation judges must apply the 2005 Permanent Disability Rating Schedule (PDRS) with the 1.4 whole person impairment (WPI) modifier[2][7][10][17][40]. This modifier replaces the former Future Earning Capacity (FEC) adjustment that applied to injuries before January 1, 2013[2][7][17][40]. The rating process requires: (1) determination of whole person impairment percentage using the American Medical Association Guides to the Evaluation of Permanent Impairment (5th Edition), (2) application of the 1.4 modifier to the WPI, and (3) adjustment for occupation and age using PDRS tables[2][13][17][40].

For injuries between January 1, 2005 and December 31, 2012, the judge must apply the 2005 PDRS using the FEC adjustment tables on pages 2-6 and 2-7 of the schedule[2][13]. For injuries prior to January 1, 2005, the judge must apply the 1997 PDRS that was in effect at the time of injury[2]. The determination of which schedule applies depends on several specific criteria: (1) the date a comprehensive medical-legal report issued indicating permanent disability, (2) the date a treating physician report indicated P&S status, or (3) whether the employer provided notice required by Labor Code Section 4061[2].

The PDRS rules for combining multiple impairments require that "regional or body system impairments are first adjusted by PDRS modifiers. Then they are combined, not as a Whole Person Percentage of Impairment but as a California-modified percentage of Permanent Disability"[2][13]. This means each body region's impairment receives separate adjustment before being combined with other body regions' disabilities[2][13]. The rules specify that "all disabilities from a particular extremity are combined to obtain an overall disability for an extremity before being combined with disabilities from other body parts"[2][13].

Medical Treatment Utilization Schedule Standards

The Medical Treatment Utilization Schedule (MTUS), adopted into Title 8, California Code of Regulations Sections 9792.20 through 9792.27, provides the evidentiary standards governing medical treatment in workers' compensation cases[38][40]. The MTUS is "presumptively correct on the issue of extent and scope of medical treatment" and provides the "primary source of guidance for treating physicians and physician reviewers for the evaluation and treatment of injured workers"[38][40]. This means that medical treatment recommendations in compliance with MTUS guidelines are presumed reasonable and necessary[38][40].

The MTUS is based on Evidence-Based Medicine (EBM) principles, requiring that treatment decisions be guided by recommendations supported by the best-available evidence rather than intuition or unsystematic clinical experience[40]. The guidelines consist of treatment recommendations adopted from the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, supplemented by additional guidelines for acupuncture, chronic pain, and post-surgical therapy[38][40].

In F&A trials, judges will approve future medical treatment as part of the award when treating physicians or medical evaluators recommend specific treatments based on MTUS guidelines[3][10][29]. If a treating physician recommends treatment not addressed by the MTUS guidelines, the physician bears the burden of

establishing that the treatment is medically necessary and supported by scientific medical evidence[40]. The judge will determine whether to approve such treatment in the F&A award based on whether the evidence supports medical necessity[3][29].

Appeal and Reconsideration Process

Petition for Reconsideration Standards and Deadlines

After the judge issues a Finding and Award, either party dissatisfied with the decision may file a Petition for Reconsideration with the WCAB within a specific deadline[31][32]. Labor Code Section 5903 establishes a basic 20-day deadline for filing the petition after service of the final F&A[31][32]. However, California Code of Regulations Section 10605 extends this deadline based on service method and location: if the defendant is served at an address outside California but within the United States, all parties receive an additional 10 days, potentially extending the deadline to 30 days from service[31].

The grounds for petition for reconsideration are strictly limited to: (1) that the appeals board or workers' compensation judge acted in excess of its power, (2) that the decision was procured by fraud, (3) that the decision is not justified by the evidence, (4) that there is newly discovered evidence which could not have been produced at the hearing, or (5) that the findings of fact do not support the decision[32]. A party cannot simply disagree with the judge's interpretation of evidence or credibility determinations; the petitioner must demonstrate one of these specific grounds[31][32].

The workers' compensation judge has fifteen days from the petition filing to prepare a report and recommendation explaining the decision in light of the petition arguments[32]. During this same period, the judge may amend, modify, or rescind the decision or conduct further proceedings[32]. The Appeals Board must act on the petition within sixty days of its filing; if the board does not act within this period, the petition is deemed denied by operation of law[32]. If the petition is granted, the board may order a new trial, modify the decision, or issue other appropriate relief[32].

Successful Reconsideration and Reopening

Successful petitions for reconsideration are comparatively rare, requiring demonstration of substantial error or newly discovered evidence that substantially affects the decision[31][32]. Recent WCAB decisions emphasize that procedural compliance failures—such as improper identification of parties or failure to meet specific filing requirements—constitute proper grounds for reconsideration[26]. If a party successfully petitions for reconsideration based on newly discovered medical evidence, the judge may order a new trial addressing the additional evidence[32].

An injured worker can also petition to reopen a F&A award (distinct from petition for reconsideration) if the worker's condition worsens within five years of the date of injury[21][24]. Labor Code Section 5803 permits the Appeals Board to revisit and change previous awards "if they notify all involved parties and allow them to present their case" and if "the board can adjust the compensation amount based on changes in the person's disability status, whether it has increased, decreased, returned, or gone away"[11][21][24]. This reopening right provides critical protection for workers whose injuries deteriorate after initial settlement[21][24].

Writ of Review and Federal Court Challenges

If a party remains dissatisfied after WCAB reconsideration proceedings are exhausted, the party may seek review by the California Court of Appeal through a Petition for Writ of Review under Labor Code Sections 5950 et sequentia[15][32]. This petition must be filed within 45 days of the final WCAB decision[15]. The court of appeal will review the WCAB decision only to determine whether the board lacked jurisdiction, acted in excess of its powers, or rendered a decision unsupported by substantial evidence[15][32].

The appellate standard is highly deferential—the court will uphold the WCAB decision so long as substantial evidence supports it[15][32]. Federal court review of state workers' compensation decisions is limited to constitutional due process violations, civil rights violations, or issues implicating federal law[15]. The vast majority of F&A awards are never appealed, indicating that most workers accept the judicial determination or negotiate informal modifications with the insurance carrier[23][31][32].

Procedural Requirements and Timeline Analysis

Application for Adjudication Filing Requirements

The process toward a Finding and Award begins with filing an Application for Adjudication of Claim with the WCAB if the claims administrator denies the claim or if significant disputes arise[12][23]. The injured worker has one year from the date of injury to file this application; failure to file within this deadline may result in waiver of benefits for the period of delay, though extensions are available for good cause[12][23]. The application should be filed as soon as possible after denial to maximize recovery and create a complete appellate record[12][23].

The application must include: (1) identification of all parties including the injured worker, employer, and insurance carrier, (2) date and description of the work injury, (3) body parts claimed injured, (4) benefits being sought, and (5) any medical evidence available[12][23][42]. Supporting documentation should include any denial letters from the claims administrator, medical reports establishing the work-relatedness of the injury, evidence of lost wages, and documentation of medical treatment sought[12][23].

Discovery and Evidence Gathering Phase

After the application is filed, parties typically spend three to six months completing discovery—the process of exchanging medical records, employment records, and other evidence relevant to the dispute[23][42]. WCAB rules require that "the parties shall be prepared to set the matter for trial or to provide a plan to complete discovery" at each priority or status conference[42]. Parties can compel production of documents through Requests for Production of Documents (governed by California Code of Civil Procedure Section 2031.010) and can depose witnesses through the deposition process governed by California Code of Civil Procedure Sections 2025.010 et sequentia[39][42].

Depositions are particularly important for obtaining testimony from treating physicians, qualified medical evaluators, and other medical professionals regarding the injured worker's condition, prognosis, and permanent disability[39][42]. The injured worker may request that the insurance company deposition be conducted at a location within 100 miles of the worker's residence, and the insurance company must reimburse the worker for lost wages and reasonable travel expenses to attend the deposition[39]. Medical evidence obtained through depositions becomes part of the trial record and can be introduced as exhibits[39][42].

Mandatory Settlement Conference Timeline

After discovery is complete, the case is typically set for a Mandatory Settlement Conference (MSC) within 6 to 12 months of the original application filing[9][23]. The MSC typically occurs in the afternoon or early evening to accommodate insurance company representatives and attorney schedules[9]. At the MSC, parties attempt to resolve disputed issues and reach settlement[6][9]. If settlement cannot be reached, the judge and parties work together to finalize the Pre-Trial Conference Statement specifying trial issues, witnesses, and exhibits[6][9].

The MSC process can extend 2 to 4 hours for complex cases, with the judge conducting separate caucuses with each party to discuss settlement value and potential compromise[9][23]. Some judges encourage continued settlement discussions between MSC and trial date, with informal settlement negotiations potentially resolving cases that were unsettled at the mandatory conference[9][23]. If a case remains unresolved after the MSC, the judge sets it for trial within 30 to 120 days[23][42].

Trial and Decision Timeline

Trial dates can be delayed due to court calendar congestion, and cases set for trial may wait several months before an actual trial date is scheduled[23]. Once trial commences, the trial typically requires 1 to 4 hours of hearing time depending on case complexity, number of witnesses, and volume of medical evidence[29][42]. The judge has 30 days after trial to issue the F&A written decision[29][31].

In practice, the complete timeline from injury to final F&A award typically requires: (1) Claim filing and 90-day investigation period: 0-3 months, (2) Denial appeal and Application for Adjudication filing: 3-6 months, (3) Discovery and evidence gathering: 6-12 months, (4) Mandatory Settlement Conference scheduling and attendance: 12-15 months, (5) Trial setting and scheduling: 15-18 months, (6) Trial and decision: 18-24 months[23]. Cases with particularly complex medical issues, multiple witnesses, or significant disputes can

extend to 24-36 months[23]. Conversely, cases with clear liability and strong medical evidence may resolve within 12-18 months[23].

Future Medical Treatment and Supplemental Benefits

Ongoing Medical Care Under F&A Awards

A critical advantage of Finding and Award settlements over Compromise and Release agreements is the preservation of ongoing medical treatment entitlement[3][10][16][18]. Under a F&A award, "future medical care" is preserved, meaning the injured worker retains "on-going right to medical treatment for a work-related injury usually determined by an authorized treating doctor or medical legal evaluator upon declaration of permanent and stationary status"[20]. This means that once the judge issues a F&A award, the claims administrator remains obligated to pay for all medically necessary treatment related to the industrial injury, subject to MTUS guidelines[3][10][16][18].

The scope of future medical care extends to treatment for any body part and condition found to be part of the industrial injury[3][10][29]. If the injured worker develops complications, needs surgery, requires ongoing physical therapy, or requires prescription medications related to the work injury, the claims administrator must authorize and pay for this treatment indefinitely[3][10][16][18]. The worker does not assume the financial risk of unexpected medical needs, unlike in C&R settlements where all future medical care must be paid from the lump-sum settlement amount[3][5][16][18][19].

However, the scope of authorized treatment is limited to that which is reasonable and necessary to cure or relieve the effects of the injury, as determined by MTUS guidelines[38][40]. If the treating physician recommends treatment not consistent with MTUS guidelines, the treating physician must present evidence establishing medical necessity and effectiveness[40]. The claims administrator may request utilization review (UR) of treatment recommendations, and if the UR physician disagrees with the recommendation, an independent medical review (IMR) process provides the worker's opportunity to challenge the UR denial[18][43].

Supplemental Job Displacement Benefit (SJDB) Vouchers

For injuries occurring on or after January 1, 2004, workers with permanent partial disability who cannot return to their pre-injury job may be entitled to Supplemental Job Displacement Benefits (SJDB), commonly called "vouchers"[27][28]. The SJDB provides funding for vocational retraining, skill enhancement, or education to help the injured worker return to suitable employment[27][28]. For injuries on or after January 1, 2013, the employer's liability for the SJDB voucher is triggered when the worker remains unable to return to work sixty days after the claims administrator receives notification of permanent and stationary status[27].

The judge must determine in the F&A whether the injured worker is entitled to an SJDB voucher[3][10][29]. Eligibility requires: (1) permanent partial disability, (2) inability to return to the pre-injury job with the same employer at substantially the same wages, and (3) the employer's failure to offer suitable alternative or modified work within the required timeframe[27][28]. If the worker is entitled to the voucher, the F&A award specifies the voucher amount available for the worker's retraining expenses[3][10][27][28].

Temporary Disability and Wage Loss Coverage

If the injured worker has not returned to full-duty work at the time of the F&A award, the judge may also determine that temporary disability benefits should continue pending return to work or until permanent total disability status is established[3][10][29][43]. Temporary disability pays two-thirds of the worker's gross pre-injury wages (up to the maximum weekly rate established by the SAWW), with the 2025 maximum TTD rate of \$1,680.29 per week[36][43].

The judge calculates temporary disability payments based on the worker's pre-injury average weekly wages, the period during which the worker was unable to work due to the injury, and whether the employer offered suitable return-to-work employment[3][10][29][43]. The judge must also address whether the worker is entitled to supplemental job displacement benefit vouchers and the amount available[3][10][27][28][29].

Mileage Reimbursement and Out-of-Pocket Expenses

The F&A award may also include reimbursement for medical travel expenses and out-of-pocket costs related to workers' compensation treatment[3][7][10][28]. Injured workers are entitled to reimbursement for reasonable travel expenses to medical appointments, including mileage, parking, and bridge tolls[7][10][28]. The 2025 mileage rate is \$0.725 per mile for travel to and from medical appointments[7][36].

If the worker has incurred reasonable and necessary medical treatment expenses not reimbursed by the claims administrator-such as co-payments required under a health plan, pharmacy costs, or medical equipment purchases-the worker may seek reimbursement through the F&A award[3][10][28]. However, the judge will only reimburse expenses for treatment rendered before the F&A award that were medically necessary and reasonable[3][29].

Lien Claims and Third-Party Subrogation

Health Care Provider Liens

Health care providers who treat injured workers frequently file lien claims against workers' compensation awards, asserting that they are entitled to reimbursement from the award before the worker receives payment[22][25]. These liens are filed pursuant to Labor Code Section 4900 et sequentia, which permits providers to seek reimbursement from workers' compensation benefits[22][25]. Common lien claimants include hospitals, physicians, chiropractors, physical therapists, and other medical providers[22][25].

The judge must determine the validity and amount of all lien claims in the F&A award[3][22][25]. Lien claims must be filed in compliance with WCAB Rule 10862, which requires filing with OCR lien claim forms, proof of service, verification under penalty of perjury, and service on all parties[25]. Untimely or defectively filed liens may be rejected[25]. The judge must address whether the lien amount is reasonable and properly documented in the F&A award[3][22][25].

Employer Subrogation Rights

If the injured worker received workers' compensation benefits and subsequently recovers damages from a third party responsible for the injury, the employer is entitled to a lien against the third-party recovery[22]. This subrogation right is established by Labor Code Section 3852, which provides that "any employer who pays, or becomes obligated to pay compensation...may likewise make a claim or bring an action against the third person"[22]. The amount of the employer's lien is the total amount of workers' compensation benefits paid[22].

The priority of liens in third-party settlements is established by Labor Code Section 3858: after paying litigation costs and attorney's fees, the employer's lien is satisfied before the injured worker receives any balance from the third-party settlement[22]. The worker can "settle around" the employer (receiving partial settlement from the third party without the employer's consent) if the settlement does not include workers' compensation benefits that have been paid-but if the worker receives compensation for lost wages that overlap with workers' compensation benefits, the employer's lien still applies[22].

Cost-Benefit Analysis and Financial Considerations

Permanent Disability Award Calculations

The monetary amount of permanent disability benefits in a F&A award depends on three primary factors: (1) the percentage of permanent disability determined by the judge (based on medical evidence and the PDRS), (2) the worker's average weekly wages at the time of injury, and (3) the date of injury (which determines whether the 1997 PDRS, 2005 PDRS, or 2005 PDRS with 1.4 modifier applies)[2][7][10][13][17][40]. The formula is: Permanent Disability Rating Percentage x Weeks Paid (determined by the PDRS table) x Average Weekly Wage Rate = Total Permanent Disability Award[2][7][10][13][17].

For example, a worker injured on January 15, 2013 with 15% permanent disability, average weekly wages of \$1,000, and no occupational or age modifiers would receive: 15% x PDRS weeks x \$1,000. The 2005 PDRS table would show a specific number of weeks for 15% disability, and that number multiplied by \$1,000 determines the total award[2][13][17]. The inclusion of occupational and age modifiers can increase or decrease this amount[2][13][17].

Research on California workers' compensation settlements indicates wide variation in award amounts based on injury severity, occupation, and disability rating[16][23]. Approximately 55% of settlements fall between \$2,000 and \$20,000, while 13% fall between \$20,001 and \$40,000, with smaller percentages achieving higher amounts[16]. The median settlement amount has historically clustered in the \$5,000 to \$15,000 range, though this varies substantially by industry and injury type[16].

Temporary Disability Wage Replacement

Temporary disability benefits provide wage replacement at the rate of two-thirds of the worker's gross pre-injury wages (subject to maximum and minimum rates established by the SAWW)[36][43]. For 2025, the minimum TTD rate is \$252.03 per week and the maximum rate is \$1,680.29 per week[36]. The worker receives these payments every two weeks while unable to work due to the injury[43].

The duration of temporary disability extends from the date the worker became unable to work until the date the physician declares permanent and stationary status, the worker returns to work, or the employer offers suitable return-to-work employment[43]. For workers with extended recovery periods, temporary disability benefits can accumulate to substantial amounts—for example, six months of TTD at maximum rate equals approximately \$43,688 in gross benefits[36][43].

Vocational Rehabilitation and SJDB Voucher Value

The value of supplemental job displacement benefit vouchers varies based on the worker's age and length of pre-injury employment[27][28]. The voucher provides retraining funds that the worker can use for educational programs, tuition, books, and related expenses at accredited schools[27][28]. A worker age 50 or older with more than 10 years of pre-injury employment with the employer may receive larger voucher amounts than younger workers with shorter tenure[27][28].

The SJDB voucher provides meaningful economic benefit to workers who would otherwise face difficulty returning to work. For example, a worker who uses a \$6,000 voucher to complete a computer programming bootcamp might transition from a \$15/hour manual labor position to a \$35/hour technology position, substantially improving lifetime earning capacity[27][28]. However, the voucher benefit depends entirely on the worker's willingness and ability to pursue education or training[27][28].

Attorney's Fees and Costs

If the injured worker is represented by an attorney, the attorney's fee is established by Labor Code Section 5307, which generally limits attorney's fees to 10% to 15% of the additional benefits obtained through representation[23][29]. The judge approves the specific attorney's fee amount in the F&A award or through a separate petition[23][29]. Additionally, the worker's attorney recovers reasonable costs of representation, including deposition costs, expert witness fees, records acquisition costs, and filing fees[22][23][29].

The deductibility of attorney's fees and costs from F&A awards means that the worker's net benefit is reduced by these expenses[22][23][29]. A worker receiving a \$50,000 F&A award with 15% attorney's fees (\$7,500) and \$2,000 in costs would net \$40,500[22][23][29]. However, this representation cost is justified if the attorney obtains significantly more favorable awards than the worker could obtain through unrepresented negotiation[23][29].

Conclusion and Strategic Recommendations

Summary of Key Findings

A Judicial Finding and Award in California workers' compensation represents a critical settlement mechanism distinct from Compromise and Release agreements and Stipulations with Request for Award. The F&A process involves mandatory settlement conferences, comprehensive medical evidence presentation through qualified medical evaluators and treating physicians, and judicial determination of all compensation issues based on substantial evidence and preponderance of the evidence standards. The process typically requires twelve to twenty-four months from injury to final award, depending on case complexity and dispute intensity.

The F&A award preserves the injured worker's right to ongoing future medical care, allows for claim reopening within five years if disability worsens, and creates defined periodic payments based on the judicially-determined permanent disability percentage. Unlike C&R settlements that provide immediate lump-

sum finality, F&As distribute benefits over extended periods while maintaining medical care entitlements indefinitely. This structure protects workers whose injuries may worsen unexpectedly or whose long-term medical needs cannot be reliably predicted at initial settlement.

The legal framework governing F&As appears primarily in California Labor Code Sections 5000-5814.5 and implementing regulations in Title 8 California Code of Regulations. Medical evidence standards derive from the Medical Treatment Utilization Schedule (MTUS) and Permanent Disability Rating Schedule (PDRS), with determinations based on evidence meeting the preponderance of the evidence standard (more likely than not). Appeal options through petition for reconsideration and writ of review exist but face high barriers due to the deferential appellate standard applied to WCAB decisions.

Framework for Decision-Making

Injured workers and their attorneys should select F&A awards as their settlement strategy when: (1) the injury's long-term consequences remain uncertain, (2) medical prognosis suggests potential for worsening or complication, (3) the worker is young with extended working career ahead, (4) occupational factors suggest ongoing disability risk, (5) the insurance carrier's settlement offers appear inadequate relative to true future value, or (6) the worker values long-term medical security over immediate lump-sum availability. The F&A approach proves most protective for workers with degenerative conditions, progressive injuries, occupational diseases with delayed manifestation, or psychological injuries developing over extended periods.

Conversely, workers should pursue C&R or Stip settlements when the injury has clearly stabilized, medical prognosis is positive and certain, future medical needs appear minimal, the worker has successfully returned to work at comparable or better wages, the worker values immediate financial control and certainty, or the worker intends to relocate outside California. The risk-benefit analysis should incorporate the worker's age, the injury's nature and severity, available medical evidence quality, settlement offer adequacy, and the worker's personal financial circumstances and risk tolerance.

Recommendations for Northern California Practitioners

For San Francisco-based immigration law practitioners noting this research request outside their typical practice area, this comprehensive analysis addresses a substantially different legal field. However, if immigration-connected clients require workers' compensation representation, the framework presented here provides necessary foundational knowledge. Practitioners should recognize that workers' compensation benefits are available to all injured employees regardless of immigration status, and that F&A awards preserve crucial benefits for workers whose future status may shift unexpectedly.

For practitioners handling workers' compensation cases, the current legal landscape (March 2026) provides stable statutory and regulatory authority supporting F&A awards. The 2025 wage rate adjustments (3.77588% SAWW increase) should be incorporated into benefit calculations. Practitioners should ensure compliance with WCAB Rule 10759 requirements for Pre-Trial Conference Statements, proper exhibit identification, and timely filing of medical evidence. The five-year reopening window provides strategic leverage in settlement negotiations by protecting workers from settlement of claims for conditions that may later worsen.

Final Notes on Procedural Implementation

The timeline from injury to final F&A award typically extends 18-24 months, with variations based on case complexity, settlement willingness, and court calendar availability in the specific WCAB district. Practitioners should file Applications for Adjudication promptly after claim denial rather than delaying, as early filing establishes better appellate records and preserves evidence. During discovery and preparation for mandatory settlement conference, practitioners should obtain comprehensive medical evidence addressing permanent and stationary status, permanent disability rating, and future medical care needs.

The substantial evidence standard applied at trial requires that all major issues be addressed through evidence that is reasonable, credible, and of solid value. Practitioners should prepare thorough witness examination plans, obtain detailed medical-legal reports from qualified medical evaluators addressing all PDRS factors, and ensure that occupational and age modifiers are properly applied in disability calculations. The appellate process following F&A issuance imposes high barriers to reversal, making trial-level success critical-petitions for reconsideration should be filed strategically only when genuine grounds under Labor Code Section 5903 exist, as frivolous petitions may result in sanctions or bad faith findings.

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