INTRODUCTION TO WORKERS COMPENSATION

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I was injured at work

español

Workers' compensation benefits are designed to provide you with the medical treatment you need to recover from your work related injury or illness, partially replace the wages you lose while you are recovering, and help you return to work. Workers' compensation benefits do not include damages for pain and suffering or punitive damages.

Report the injury or illness to your employer

Make sure your supervisor is notified of your injury as soon as possible. If your injury or illness developed gradually, report it as soon as you learn or believe it was caused by your job. Reporting promptly helps avoid problems and delays in receiving benefits, including medical care. If you don't report your injury within 30 days, you could lose your right to receive workers' compensation benefits.

Get emergency treatment if needed

If it's an emergency, call 911 or go to an emergency room right away. Tell the medical staff that your injury or illness is job-related. If you can safely do so, contact your employer for further instructions.

If you don't need emergency treatment, make sure you get first aid and see a doctor if necessary.

What's next?

Once you file a claim, your employer is required to provide you with medical care.

Want to learn more? Find it in the guidebook

- Chapter 1: The Basics of Workers' Compensation
- Want a complete version of the injured worker guidebook?

Did you know?

- You can attend a free online workshop on workers' compensation or contact the Information and Assistance Unit if you have questions. You can also call the DWC Information Services Center at 1-800-736-7401 to speak to a live representative.
- Medical care must be paid for by your employer if you get hurt on the job — whether or not you miss time from work.
- You may be eligible to receive benefits even if you are a temporary or part-time worker.

- You don't have to be a legal resident of the United States to receive most workers' compensation benefits.
- It's illegal for your employer to punish or fire you for having a job injury or for requesting workers' compensation benefits when you believe your injury was caused by your job.
- You can find the definitions of common terms and abbreviations in the glossary for injured workers.
- Fact sheets and claim forms are available in Chinese, Korean, Spanish, Tagalog, and Vietnamese.

Questions workers have:

- What benefits am I entitled to?
- Do I need to fill out the claim form (DWC 1) my employer gave me?
- What resources are available to me?
- How can I find out who provides workers compensation coverage for my employer or another business in California?
  ➲ More FAQs

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Division of Workers' Compensation

Factsheet

What is workers' compensation?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.
—or—
Repeated exposures at work. Examples: hurting your wrist from doing the same motion over and over, losing your hearing because of constant loud noise.

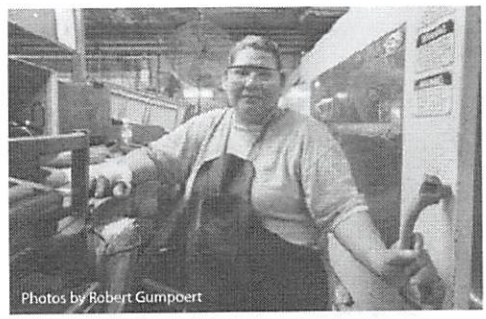
What are the benefits?

- **Medical care:** Paid for by your employer, to help you recover from an injury or illness caused by work.
- **Temporary disability benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering.
- **Permanent disability benefits:** Payments if you don't recover completely.
- **Supplemental job displacement benefits** (if your date of injury is in 2004 or later): Vouchers to help pay for retraining or skill enhancement if you don't recover completely and don't return to work for your employer.
- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness.

What should I do if I have a job injury?

Report the injury to your employer

Tell your supervisor right away. If your injury or illness developed gradually (like tendinitis or hearing loss), report it as soon as you learn or believe it was caused by your job.



Minimizing the impact of work-related injuries and illnesses

Helping resolve disputes over workers' compensation benefits

Monitoring the administration of claims

Get emergency treatment if needed

If it's a medical emergency, go to an emergency room right away. Your employer may tell you where to go for treatment. Tell the health care provider who treats you that your injury or illness is job-related.

Fill out a claim form and give it to your employer

Your employer must give or mail you a claim form (DWC 1) within one working day after learning about your injury or illness. Use it to request workers' compensation benefits.

Get good medical care

Get good medical care to help you recover. You should be treated by a doctor who understands your particular type of injury or illness. Tell the doctor about your symptoms and the events at work that you believe caused them. Also describe your job and your work environment.

Call 1-800-736-7401 to hear recorded information on a variety of workers' compensation topics 24 hours a day, or go on line to www.dwc.ca.gov to find the I & A office near you.

I'm afraid I might be fired because of my injury. Can my employer fire me?

It's illegal for your employer to punish or fire you for having a job injury, or for filing a workers' compensation claim when you believe your injury was caused by your job.

If you feel your job is threatened, find someone who can help. Note that there are deadlines for taking action to protect your rights.

The California Division of Workers' Compensation (DWC) is the state agency that oversees the delivery of benefits for injured workers and helps resolve disputes over benefits between injured workers and employers.

DWC information and assistance (I & A) officers can help you navigate the workers' compensation system, and can provide claim forms or other forms you need to receive benefits.

The FREE publication, "A Guidebook for Injured Workers," can be downloaded from www.dwc.ca.gov.

Please visit the
Division of Workers' Compensation
Web site at: www.dwc.ca.gov
or call 1-800-736-7401

Department of Industrial Relations 1515 Clay Street, 17th Floor, Oakland, CA 94612 www.dir.ca.gov
July 2010

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Chapter 1. The Basics of Workers' Compensation

What is workers' compensation?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

- **One event at work.** Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

  or:

- **Repeated exposures at work.** Examples: hurting your hand, back, or other part of the body from doing the same motion over and over, losing your hearing because of constant loud noise.

Workers' compensation covers some, but not all, stress-related (psychological) injuries caused by your job. Also, workers' compensation may not cover an injury that is reported to the employer after the worker is told he or she will be terminated or laid off. For information about what is covered, use the resources in Chapter 10.

What are the benefits?

They can include:

Medical Care. Paid for by your employer, to help you recover from an injury or illness caused by work. This includes doctor visits and other treatment services, tests, medicines, equipment, and travel costs reasonably necessary to treat your injury.

Temporary Disability Benefits. Payments if you lose wages because your injury prevents you from doing your usual job while recovering.

Permanent Disability Benefits. Payments if you don't recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.

Supplemental Job Displacement Benefit. A voucher to help pay for retraining or skill enhancement if you are eligible to receive permanent disability benefits, your employer doesn't offer you work, and you don't return to work for your employer. This benefit is available for workers injured in 2004 or later. If your injury also occurred in 2013 or later and you received a Supplemental Job Displacement Benefit, you may also be eligible for an additional, one-time payment under the Return-to-Work Supplement Program.

Death Benefits. Payments to your spouse, children, or other dependents if you die from a job injury or illness.

For examples of workers' compensation payments, see p. 5.

Can my regular doctor treat me if I get hurt on the job?

It depends on whether you tell your employer in ***writing—before*** you are injured—the name and address of your personal physician or a medical group. This is called "predesignating." If you predesignate, you may see your personal physician or the medical group right after you are injured.

How to predesignate

To predesignate your personal physician (if you are eligible to do so), you must notify your employer in writing. You may prepare your own written statement, use optional DWC Form 9783 provided by the Division of Workers' Compensation, or use a form provided by your employer. To download DWC Form 9783, go to *www.dir.ca.gov/dwc/forms.html*.

Note: If your employer or the insurer has a contract with a health care organization (HCO), you must use a different form, discussed on the next page.

Make sure to include the following information:

1. Name of your employer
2. A statement that if you are hurt on the job, you designate your personal physician to provide medical care. Give the name, address, and phone number of your physician.
3. Your name
4. Your signature
5. Date

You can predesignate a doctor of medicine (MD) or doctor of osteopathy (DO) who treated you in the past and has your medical records. The doctor must be a general practitioner, internist, pediatrician, obstetrician-gynecologist, or family practitioner who is your primary care physician.

You cannot predesignate your personal chiropractor or acupuncturist, but if you give your employer the name of your personal chiropractor or acupuncturist in writing before you are injured, you may switch to this chiropractor or acupuncturist upon request, after you first see a doctor chosen by a claims administrator (a person who handles workers' compensation claims for your employer).

You may also predesignate a medical group if it meets the following criteria:

- Is composed of licensed doctors of medicine (MD) or doctors of osteopathy (DO)
- Offers and coordinates both primary care and care in other medical specialties
- Mostly treats medical conditions that are unrelated to work

You cannot predesignate unless the physician or medical group you predesignate agrees in advance to treat you for job injuries and illnesses. You can document the agreement by having the physician, an employee of the physician, or an employee of the medical group sign the predesignation form, or by some other form of documentation. Include the documentation when you give your employer the predesignation form or statement.

If you predesignate, you may see your personal physician or medical group right after you are injured.

Can all workers predesignate?

No. You can predesignate only if, on your date of injury, you have health care coverage for medical conditions that are unrelated to work. If you do not have this coverage, you do not have a right to predesignate.

Are there different rules for predesignating if my employer or the insurer has a contract with a health care organization (HCO)?

Yes. A health care organization (HCO) is an organization certified by the Division of Workers' Compensation to provide managed medical care to injured workers. If your employer or the insurer has a contract with an HCO, the employer or insurer must give you DWC Form 1194 within 30 days after your date of hire and at least once a year. You can use this form to predesignate your personal physician, personal chiropractor, or personal acupuncturist. You are not required to show that your doctor agreed to be predesignated. If you do not predesignate each time you are given this form, your employer will enroll you in the HCO and you will be treated in the HCO for job-related injuries.

What should I do if I get hurt at work or develop a work-related medical problem?

Report the injury or illness to your employer. Make sure your supervisor or someone else in management knows as soon as possible. If your injury or illness developed gradually (like tendinitis or hearing loss), report it as soon as you learn or believe it was caused by your job. Reporting promptly helps avoid problems and delays in receiving benefits, including medical care. If your employer does not learn about your injury within 30 days, you could lose your right to receive workers' compensation benefits.

Get emergency treatment if needed. If it's an emergency, call 911 or go to an emergency room right away. Your employer must make sure that you have access to emergency treatment right away and may tell you where to go for treatment. Tell the medical staff that your injury or illness is job-related.

For more steps to take, see Chapter 2.

How can I avoid getting hurt on the job?

It's best to prevent injuries before they happen. Employers in California are required to have an Injury and Illness Prevention Program. The program must include worker training, workplace inspections, and procedures for correcting unsafe conditions promptly. Learn about and participate in your employer's program. Report unsafe conditions to your employer and union, if you have one. If they don't respond, call Cal/OSHA, the state agency that enforces health and safety laws.

Did you know?

- Medical care must be paid for by your employer if you get hurt on the job—whether or not you miss time from work.
- You may be eligible to receive benefits even if you are a temporary or part-time worker.
- You may be covered by workers' compensation as an employee even if you are called an "independent contractor."
- You don't have to be a legal resident of the United States to receive most workers' compensation benefits.
- You receive benefits no matter who was at fault for your job injury.
- You can't sue your employer for a job injury (in most cases).
- It's illegal for your employer to punish or fire you for having a job injury or for requesting workers' compensation benefits when you believe your injury was caused by your job.

Workers' Compensation Benefits—Examples

Temporary Total Disability Benefits

DATE OF INJURY	MINIMUM PAYMENTS	MAXIMUM PAYMENTS
2010	$148.00 per week	$986.69 per week
2011	$148.00 per week	$986.69 per week
2012	$151.57 per week	$1,010.50 per week
2013	$160.00 per week	$1,066.72 per week
2014	$161.19 per week	$1,074.64 per week
2015	$165.49 per week	$1,103.29 per week
2016	$169.26 per week	$1,128.43 per week

Permanent Disability Benefits—Examples

The following are only examples. They apply to workers who earned more than $435 per week before injury, and whose employer has fewer than 50 employees. The examples are not adjusted for age, occupation, or other factors causing disability (apportionment).

DISABILITY	INJURY IN 2005-12	INJURY IN 2013	INJURY IN 2014
Total loss of vision in one eye, normal vision in other eye	$19,665.00 (total)	$27,312.50 (total)	$34,437.50 (total)
Amputation of index finger at middle joint	$6,210.00 (total)	$7,877.50 (total)	$9,932.50 (total)

Supplemental Job Displacement Benefits

DATE OF INJURY	MAXIMUM BENEFIT
2004–12	$4,000 to $10,000, depending on permanent disability rating
2013 or later	$6,000

Death—Examples involving three or more total dependents

The following are only examples. Benefits are also available if there are fewer than three total dependents, or if there are partial dependents.

Burial expenses:

Date of injury before 2013: up to $5,000

Date of injury 2013 or later: $10,000

Death benefits if there are three or more total dependents:

Date of injury 2006 or later: $320,000 (total)

(Regardless of the amounts listed above, death benefits paid to a totally dependent child continue until the child reaches age 18. If the child is physically or mentally incapacitated, benefits continue until the child's death.)

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How to Use This Booklet

If you get hurt on the job, the law requires your employer to provide workers' compensation benefits. These include medical care for your injury and payments if you are unable to work or have a permanent disability because of the injury. To learn about these benefits, see *Workers' Compensation in California: A Guidebook for Injured Workers*, 3rd Edition, November 2006, along with updates after 2006. Go to: **www.dir.ca.gov/chswc** (link to "Find the most recent Guidebook for Injured Workers").

Employers in California are required to buy workers' compensation insurance from an insurance company or become self-insured through a state program. If your employer is illegally uninsured and does not provide workers' compensation benefits for your injury, you may file a civil lawsuit against your employer for personal injury. You may also file a workers' compensation claim against your employer by requesting the state Workers' Compensation Appeals Board (WCAB) to decide what benefits you have a right to receive.

To give the WCAB the legal power to determine your benefits, you must find the exact legal name of your employer and notify the employer about your claim. If the WCAB decides that you have a right to receive benefits, the WCAB will issue an award requiring your employer to pay the benefits.

If your employer does not pay you, the benefits will be paid by the Uninsured Employers Benefits Trust Fund (UEBTF). This is a special California fund that provides workers' compensation benefits when an injured worker's employer does not do so. After paying your benefits, the UEBTF will collect from your employer in civil court. The rules on how you must name and notify your employer are strict and detailed to make it possible for the UEBTF to collect from your employer.

This booklet discusses 10 basic steps to apply for benefits if your employer is illegally uninsured. If possible, you should find

someone who knows these steps to guide you through the process. Some workers hire a workers' compensation applicants' attorney to handle these steps. (Applicants' attorneys represent injured workers in workers' compensation cases.) For workers who are not able to hire an attorney, this booklet discusses how you can work with a state Information & Assistance (I&A) officer.

Information about I&A officers is given in Appendix A. Information about applicants' attorneys is given in Appendix B. Specific forms and further instructions are given in Appendices C, D, F and G. Laws, regulations, and cases that govern the rights and duties discussed in this booklet are listed in Appendix E.

Regardless of who is assisting you, you should gather and organize the materials and other information listed below to support your claim. You should continue to do so until your claim is completed and closed:

- List of witnesses to the injury
- Notes of discussions with people involved in your claim
- Notes showing the progress of your medical condition and ability to work
- Medical reports
- Police and emergency services reports
- Medical bills, receipts for prescriptions and travel to medical appointments
- Proof of employment, such as pay stubs, W-2 forms, written work instructions, and job announcements or advertisements
- Information to identify your employer, such as identification badges, business cards, and the license plate number of your employer's vehicle

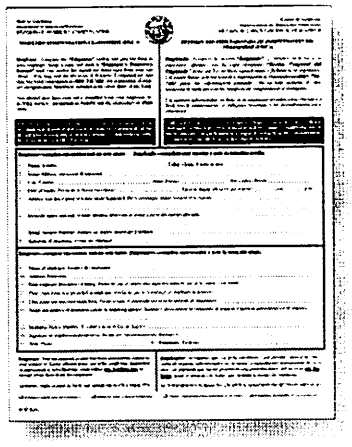
Steps to Apply for Benefits

STEP 1.
Report the Injury

If you get hurt at work or develop a work-related medical problem, report it to your employer. Make sure your boss, supervisor, or someone else in management knows as soon as possible. If your employer does not learn about your injury or illness in a timely fashion, you could lose the right to receive workers' compensation benefits.

STEP 2.
File a Claim Form

Your employer is required to give you a ***Workers' Compensation Claim Form (DWC 1).*** You use this form to request workers' compensation benefits in writing. If your employer does not give you a claim form, you can copy the one in Appendix G or get one from an Information & Assistance (I&A) officer.



Workers' Compensation Claim Form (DWC 1)

Read all of the information about workers' compensation that is attached to the form. Fill out the "Employee" portion. Type or print neatly. Describe your injury completely, and include every part of your body affected by the injury. Then sign the form. Make a copy for your records.

Give or mail the form to your employer. This is called "filing" the claim form. If mailing, use first-class or certified mail, and buy a return receipt. If you do not know where to send the form, you can ask the I&A officer for help.

STEP 3.
Identify and Correctly Name Your Employer

Ask for the name of your employer's insurance company if you think your employer is uninsured

If your employer refuses to send you for treatment or pays for your treatment directly without going through workers' compensation insurance, your employer may be uninsured. If this happens, ask your employer for the name of the employer's workers' compensation insurance company.

Search for your employer's exact legal name if you cannot get the name of the insurance company

If your employer does not give you the name of the insurance company and you suspect your employer is uninsured, do a search to find your employer's legal name. The name your employer uses may not necessarily be your employer's legal name:

- If your employer is an individual person or individual owner, the legal name is the name of that person.
- If your employer is a partnership, the legal name includes the name of each partner.
- If your employer is a corporation, limited liability company, or limited partnership, the legal name is the name your employer has on file with the California Secretary of State.

To find your employer's legal name, look in the following places:

- Paychecks or other papers from your employer
- Telephone directory
- City's business licensing bureau
- City or county tax assessor's office
- County clerk's "Fictitious Business Name" index, which lists true legal names of some businesses and the names they are doing business as ("DBA")
- California Secretary of State: **www.sos.ca.gov** (link to "Business Entities," then link to "Business Search")
- California Department of Consumer Affairs, Contractors State License Board: **www.cslb.ca.gov** (link to "Consumers," then link to "Check a License")

Ask for help if necessary

If you cannot find your employer's legal name, you can ask the I&A officer for help to request information from the Office of the Director of Industrial Relations, Legal Unit, which represents the UEBTF. This office is also called OD Legal. See the instructions in the box below.

To request information from OD Legal:

1. Describe everything you have done to:
   a. Identify the employer;
   b. Find out whether it is an individual, a partnership or association, or a corporation or company;
   c. Find its address.
2. State that in spite of these efforts you cannot find the information needed.
3. State that the information is necessary to bring legal action against the employer to allow you to apply for benefits

Write out the legal name of your employer

Use the information you found to write out all possible versions of your employer's legal name. See the box below.

Naming your employer

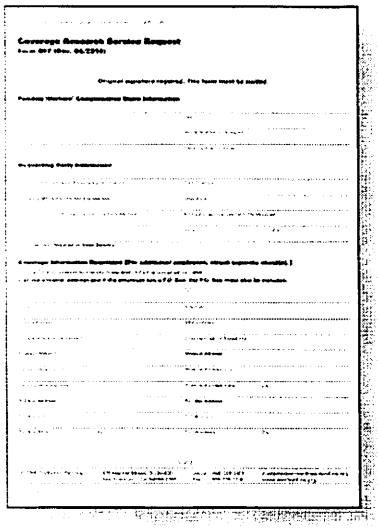
- If your employer is an individual person or a partnership, write each person's first name, middle initial (if known), and last name. (Example: Thomas R. Thompson and Samuel L. Smith)
- If your employer is a business owned by an individual person, write the name of the owner and the name of the business. (Example: Thomas R. Thompson, individually and doing business as Tom's Tires, and Tom's Tires, a proprietorship)
- If your employer is a business owned by a partnership, write the names of the owners and the name of the business. (Example: Thomas R. Thompson and Samuel L. Smith, individually and doing business as Tom's Tires, and Tom's Tires, a partnership)
- If your employer is another type of business entity, write its exact name. Include any division, corporate subsidiary, or fictitious business name the business uses. (Example: Toledo Tires, Inc., a Delaware corporation, individually and doing business as New Tires for Less, and New Tires for Less)

STEP 4.

Request Information About Coverage

You can ask the I&A officer whether he or she can do a search

To learn whether your employer has workers' compensation insurance, you can ask whether the I&A officer can do a search in the database of the Workers' Compensation Insurance Rating Bureau (WCIRB), or whether he or she can contact the WCIRB directly.



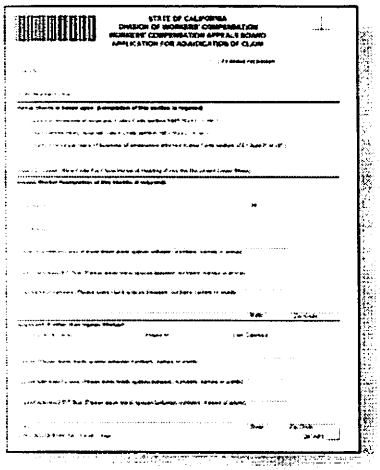
Coverage Research Service Request

Request services from the WCIRB if necessary

If the I&A officer cannot do a search and cannot contact the WCIRB directly, fill out a *Coverage Research Service Request* form to ask the WCIRB to search their records for information about your employer's workers' compensation insurance. Type or print neatly. You can copy the form in Appendix G or ask the I&A officer for the form. Fill out the form, listing all possible names that your employer uses. Sign the form. Mail the completed form to the WCIRB at the address shown on the form. No fee is charged to injured workers. Expect a reply in two to six weeks. If the WCIRB states that no insurance coverage was found, go to the next step.

STEP 5.

File an Application for Adjudication of Claim



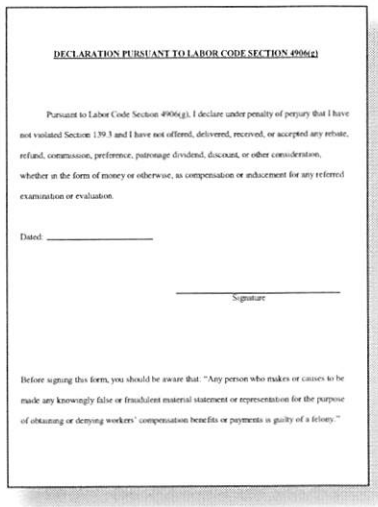
Application for Adjudication of Claim

Fill out and sign an *Application for Adjudication of Claim* form. You use this form to open a case and request a workers' compensation judge to decide what benefits you have a right to receive. You can fill out the form with the I&A officer. The form is shown in Appendix F.

The form asks for your employer's name. Use the name(s) you wrote out in Step 3. If you could not find the true legal name of your employer even after asking for help from the I&A officer, write all the names you think the employer uses and the names of all the persons who appear to be in charge of the business. When you later learn the true legal name of your employer, you must amend (revise) the Application.

Next, sign a *Declaration Pursuant to Labor Code Section 4906(g).* This declaration states that you do not have a financial interest in medical tests or examinations. You can do this with the I&A officer. A sample Declaration is shown in Appendix F.

With the I&A officer, file copies of the Application, the Declaration, and the Workers' Compensation Claim Form with the Workers' Compensation Appeals Board. The WCAB office will mail you a notice with your case number on it.



DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: _____

_____
Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

Declaration Pursuant to Labor Code Section 4906(g)

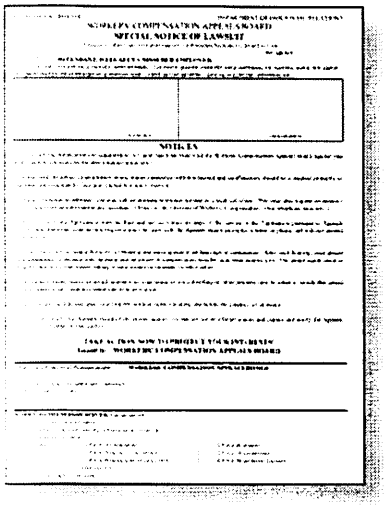
STEP 6.
File in Bankruptcy Court If Applicable

Bankruptcy means that a court decides what will happen when a company does not have enough money to pay its debts, including workers' compensation claims filed by employees. A bankruptcy court has the power to stop workers' compensation proceedings. Stopping workers' compensation proceedings is called a "stay."

If you have received a notice that your employer is filing for bankruptcy, file a "proof of claim" in the bankruptcy proceeding and request "relief" from the court's stay of your workers' compensation proceedings. You must do this to preserve, or protect, the right to obtain workers' compensation benefits from your employer or from the Uninsured Employers Benefits Trust Fund (UEBTF).

If possible, hire a bankruptcy attorney to take these actions to protect your rights, such as an attorney who is certified by the State Bar of California as a specialist in bankruptcy law. You can get names of certified specialists from the State Bar (website: **www.calbar.ca.gov**), a local bar association, a county legal aid society, or your union (if you have one). You can also contact the State Bar of California about lawyer referral services (phone toll-free in California: 1-866-442-2529; website: **www.calbar.ca.gov**), or check the yellow pages of a phone book and look under: Attorney Referral Service.

STEP 7.
Fill Out a Special Notice of Lawsuit Form



Special Notice of Lawsuit

Fill out and sign a *Special Notice of Lawsuit* form. You use this form to notify your employer about the application you filed with the WCAB. You can copy and use the form in Appendix G. Type or print neatly. Fill out and sign the form. In the "Defendant(s)" space, use the name of your employer that you wrote out in Step 3.

If you cannot find the true legal name of your employer even after asking for help from the I&A officer, write the names you think the employer uses and the names of the persons who appear to be in charge of the business. When you later learn the true legal name of your employer, you must amend (revise) the *Special Notice of Lawsuit.*

STEP 8.
Establish Personal Jurisdiction Over Your Employer

The WCAB must establish "personal jurisdiction" over your employer to have the legal power to decide whether your employer is required to pay workers' compensation benefits for your injury. Below are two different ways to establish personal jurisdiction. Option B is the traditional method. Option A is easier than Option B. However, if Option A does not work, you must do Option B. Discuss with the I&A officer whether the local office of the WCAB can do Option A.

OPTION A: REQUEST A HEARING

The WCAB may be able to establish personal jurisdiction over your employer if your employer attends and participates in a hearing. This option can work only if you know your employer's address and include it on the papers described below. This will allow the WCAB to notify your employer about the hearing.

Ask for help to find your employer's address if necessary

If you cannot find your employer's address, you can ask the I&A officer for help to request information from OD Legal. See the instructions in the box on page 9.

Prepare papers for a hearing

Fill out and sign a *Declaration of Readiness to Proceed* form to request a hearing before a workers' compensation judge. You can do this with the I&A officer. This form is shown in Appendix F.

Declaration of Readiness to Proceed

Request that the UEBTF be included in your case

Fill out and sign a *Petition to Join Party Defendant UEBTF* form to ask that the UEBTF be included in your case. You can copy and use the form in Appendix G. Type or print neatly.

Gather papers

Create a packet of the original documents listed below, and keep them together. Make a copy of the packet to file with the WCAB. Keep the original packet for your records.

- Special Notice of Lawsuit
- Application for Adjudication of Claim
- Declaration of Readiness to Proceed
- Workers' Compensation Claim Form (or a copy)
- WCIRB reply that no insurance coverage was found
- Petition to Join Party Defendant UEBTF

Petition to Join Party Defendant UEBTF

File with the WCAB

With the I&A officer, file the copy you made of the packet described above with the WCAB.

Participate in the hearing

The WCAB will schedule a hearing before a workers' compensation judge and send a notice to all parties about the hearing date. At the hearing, be prepared to describe who you worked for when you

were injured on the job. If your employer attends and participates in the hearing, go to Step 9. If your employer does not participate in the hearing, go to Option B.

OPTION B: SERVE PROCESS AND REQUEST A HEARING

If you did not do Option A, or you tried but your employer did not appear, you must "serve process" to establish jurisdiction over your employer. Serving process means delivering papers to make sure that your employer is adequately informed about your claim. Someone besides yourself must deliver the papers.

Decide who should be served

If your employer is an individual who is the sole owner of his or her business, he or she is the person who must be served with your papers. If your employer is another type of business, see Appendix C for information on who may be served on behalf of the business.

Locate the person to be served

Use the resources in Step 3 to find the workplace of the person to be served or the place where the person receives mail. If your employer is an individual person, you may also find his or her home. If you cannot find any of this information, you can ask the I&A officer to help you request information from OD Legal. See the instructions in the box on page 9.

Prepare papers for a hearing

Fill out and sign a *Declaration of Readiness to Proceed* form to request a hearing before a workers' compensation judge. You can do this with the I&A officer. This form is shown in Appendix F.

Request that the UEBTF be included in your case

Fill out and sign a *Petition to Join Party Defendant UEBTF* form to ask that the UEBTF be included in your case. You can copy and use the form in Appendix G. Type or print neatly.

Gather papers

Create a packet of the original documents listed below, and keep them together. Make three copies of the packet: one for your employer, one for OD Legal, and one to file with the WCAB. Keep the original packet for your records.

- Special Notice of Lawsuit
- Application for Adjudication of Claim
- Declaration of Readiness to Proceed
- Workers' Compensation Claim Form (or a copy)
- WCIRB reply that no insurance coverage was found
- Petition to Join Party Defendant UEBTF

Find a process server

You must find someone besides yourself to deliver one copy of the packet to the person to be served. It is best to use the sheriff or marshal or to hire a professional process server. To find the sheriff or marshal, look in the County Government pages of your phone book. To find a professional process server, look in the Yellow Pages of your phone book. Expect to pay a fee to the sheriff, marshal, or professional process server. Keep the receipt so you can request reimbursement later from your employer or the UEBTF. The process server will deliver the packet by one of the following methods:

- Personal service, which means handing the papers directly to the person to be served
- Substituted service, which means delivering the packet to a different person and mailing a copy of the packet to the person to be served

Instruct the process server

The process server will give you forms asking for the names and addresses of the person(s) to be served and other instructions. Provide the numbers of copies of documents required by the process server. Also give the process server a *Proof of Service of Special Notice of Lawsuit* form to fill out and return to you after delivering the packet. The proof of service shows that the process server successfully served the *Special Notice of Lawsuit*. You can copy and use the form in Appendix G. The process server should

PROOF OF SERVICE – SPECIAL NOTICE OF LAWSUIT

Proof of Service of Special Notice of Lawsuit

type or print neatly, and should list on the form all the documents in the packet.

If delivery by personal service to an individual who is the sole owner of his or her business is not possible and delivery is made by substituted service, the process server will also prepare a *Declaration of Due Diligence*, which is a statement describing how the process server tried to deliver by personal service. Make two copies of the proof of service form: one for OD Legal and one to file with the WCAB. Do the same with the declaration (if one was prepared). Keep the originals for your records.

(You may also ask a friend or relative to deliver the packet, but this is not recommended unless you know that delivery will be easy and straightforward. The person who delivers the packet must be at least 18 and not listed in your claim. For instructions on how to deliver the packet by personal service or substituted service, see Appendix D.)

Ask for help if the packet cannot be delivered

If delivery by personal service or substituted service is not possible, you can ask for help from the I&A officer to do service by mail with acknowledgment of receipt, service by publication in a newspaper, or service of the Secretary of State (if your employer is a corporation).

Notify OD Legal

Ask the I&A officer for the address of the appropriate office of OD Legal, which represents the UEBTF. Mail a copy of the packet to that office. Use first-class or certified mail, and purchase a return receipt.

File with the WCAB

With the I&A officer, file a copy of the packet listed above with the WCAB, along with a copy of the *Proof of Service of Special Notice of Lawsuit* and a copy of the *Declaration of Due Diligence* (if one was prepared).

Participate in the hearing scheduled by the WCAB

Go to the hearing and be prepared to describe who you worked for when injured on the job.

STEP 9.
Receive an Order Joining the UEBTF

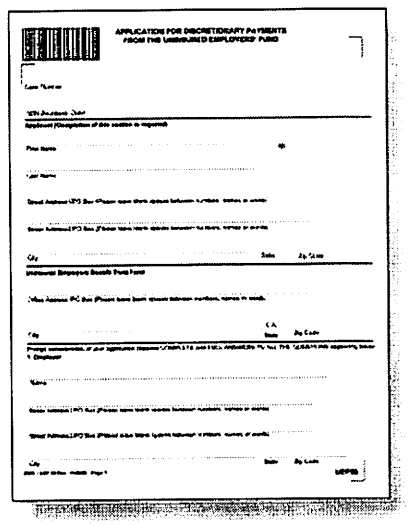
If there are no problems with the steps you took to name, notify, and establish personal jurisdiction over your employer, you will receive an order from the WCAB joining the Uninsured Employers Benefits Trust Fund (UEBTF) as a defendant in your claim. After you receive this order, give copies of important documents in your claim to the UEBTF if the WCAB asks you to do so.

STEP 10.
Request Benefits

Go to and participate in any medical examinations, meetings, and hearings required by the workers' compensation judge. The judge will review the medical reports and other information in your case to decide whether you have the right to receive workers' compensation benefits. The process could take some time, depending on how complicated your case is.

In the meantime, fill out and sign an ***Application for Discretionary Payments from the Uninsured Employers Fund***. You can do this with the I&A officer. This form is shown in Appendix F. With the I&A officer, file the application with the UEBTF. The UEBTF may provide you with benefits before the workers' compensation judge makes a decision, but is not required to do so.

If the judge decides that you should receive workers' compensation benefits, he or she will issue an award requiring your employer to pay the benefits. If you do not begin receiving benefits from your employer within 10 days after learning about your award, you can ask the I&A officer for help to obtain benefits from the UEBTF.



Application for Discretionary Payments from the Uninsured Employers Fund

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Attorney information

Workers' compensation is the nation's oldest social insurance program: It was adopted in most states, including California, during the second decade of the 20th century. Unlike most social insurance programs, workers' compensation benefits are not administered by a government agency. They are administered primarily by insurance companies and those employers secure enough to self-insure their workers' compensation liability.

When an employer becomes aware of a work-related injury or illness, it is expected to begin providing benefits to the injured worker. Sometimes a dispute may arise between the claims administrator and the injured worker over benefits. That's where you come in.

Whether you represent employees (applicants), employers/ insurance carriers or lien claimants, there is useful information on this Web site to help you do your job efficiently and knowledgably. You can find provisions of the Labor Code, California Code of Regulations and pending or proposed rules that will help guide you through the litigation process. You will also be able to easily find the address of any of our 22 district offices plus satellites in cities from Eureka to San Diego, along with a map and directions to each location. Important en banc and significant panel decisions issued by the Workers' Compensation Appeals Board can be accessed here to help you find relevant case law authority. You can even download two weeks of the workers' compensation court calendar. Finally, you can also locate Division of Workers' Compensation Newsline articles covering a wide variety of topics to keep you informed about current and proposed policies affecting your practice, including our EAMS paperless case management system.

Topics on this page include:

General information

Educational conference - DWC holds the largest workers' compensation educational conference in the state at sites in Northern and Southern California. Speakers from the division and the private sector will address the most current topics and issues confronting claims administrators, attorneys, medical providers, rehabilitation counselors, and others involved in workers' compensation.

Workers' compensation benefits - Overview of benefits, including currents rates, available for injured workers.

Late for court? Email the "Late for Court" address on district office page where you are scheduled to appear

ZIP code locator tool will help you locate the DWC district office serving your ZIP code

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Medical treatment information

Doctors in California's workers' compensation system are required to provide evidence-based medical treatment. That means they must choose treatments scientifically proven to cure or relieve work-related injuries and illnesses. Those treatments are laid out in a set of guidelines that provide details on which treatments are effective for certain injuries, as well as how often the treatment should be

given (frequency), the extent of the treatment (intensity), and for how long (duration), among other things.

To comply with the evidence-based medical treatment requirement, the state of California has adopted a medical treatment utilization schedule (MTUS). The MTUS includes specific body regions guidelines adopted from the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, plus guidelines for acupuncture, chronic pain, and therapy after surgery. The Division of Workers' Compensation also has a committee that continuously evaluates new medical evidence about treatments and incorporates that evidence into its guidelines.

Copies of the ACOEM guidelines are available for review at your local DWC office. Other guidelines not adopted from ACOEM can be reviewed and downloaded from the DWC Web site.

Copies may also be obtained from:

Division of Workers' Compensation
Medical Unit
P.O. Box 71010
Oakland, CA 94612-1486

Additionally, employers are required to have a program called utilization review (UR). UR was implemented as a way to confirm the treating physician's plan for the injured worker is medically sound. To ensure prompt and effective medical treatment is provided to injured workers, UR must be completed within strict timelines. Claims administrators who don't meet the timelines or the criteria for a proper UR program are subject to audits and penalties. Injured workers, attorneys, medical providers or others who find that UR is not being done according to the regulations can file a complaint with the DWC.

➲ More UR topics

Many employees now have their workers' comp injuries cared for by a doctor in a medical provider network (MPN) or a health care organization (HCO). These networks of doctors are similar to health maintenance organizations (HMOs).

Searchable lists of approved medical provider networks are now available on the Department of Industrial Relations' Open Data Portal at CA.gov

- Current list approved medical provider networks by approval date
- Current list of approved medical provider networks by name of applicant

➲ More medical provider network topics

Your client and/or the claims administrator might disagree with what the treating doctor says about a work injury or treatment. There could be other disagreements over medical issues in the claim. A doctor has to address those disagreements. In that case you and the defense attorney may agree on a medical evaluator (AME) or, if you can't agree, your client will see a qualified medical evaluator (QME).

Online QME Form 106 Panel Request - Online only as of Oct. 1, 2015. No paper submissions postmarked after Sept. 3, 2015.

Frequently asked questions about QMEs

Qualified Medical Evaluator database (QME)
Discipline unit
➲ More QME topics

Certified Health Care Organizations
➲ More health care organization topics

Official medical fee schedule

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Disability ratings

Most workers fully recover from job injuries but some continue to have medical problems. Permanent disability (PD) is any lasting disability an injured employee experiences, which results in reduced earning capacity after maximum medical improvement is reached. If an injured employee's injury or illness results in PD they are entitled to PD benefits. Check out our fact sheets and guides page and click on fact sheet D for more information on PD.

For injuries occurring on or after Jan. 1, 2013, there will be a new method for calculating an injured employee's PD rating. A QME or treating physician can no longer increase an injured employee's PD by adding impairment in the form of sleep disorder or sexual impairment unless such impairments were a direct result of the injury. In addition, no increase in an injured employee's PD on account of a psychiatric injury is allowed unless the physical injury was catastrophic or the injured employee was the victim of or a witness to a violent crime

Permanent disability rating schedule - 2005
This schedule is effective for dates of injury on or after Jan. 1, 2005. This schedule will also be used to rate permanent disability in injuries that occurred before Jan. 1, 2005 when there has been either no comprehensive medical-legal report, or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide a notice to the injured worker under Labor Code section 4061.

Permanent disability rating schedule - 1997
This schedule is effective for dates of injury on or after Apr. 1, 1997

Answers to practitioners' questions about applying the permanent disability rating schedule

Commutation templates and instructions .zip file
Templates and instructions to facilitate the calculation of life pension and permanent disability benefit commutations. When properly used, the templates assure that calculations are done in accordance with commutation calculation methods and tables that went into effect Jan. 17, 2001. The regulations and tables can be found in section 10169 and 10169.1 of Title 8, California Code of Regulations.
➲ More disability rating topics

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Article XIV section 4, California Constitution:

The Legislature is hereby expressly vested with plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers' compensation, by appropriate legislation, and in that behalf to create and enforce a liability on the part of any or all persons to compensate any or all of their workers for injury or disability, and their dependents for death incurred or sustained by the said workers in the course of their employment, irrespective of the fault of any party. A complete system of workers' compensation includes adequate provisions for the comfort, health and safety and general welfare of any and all workers and those dependent upon them for support to the extent of relieving them from the consequences of any injury or death incurred or sustained by workers in the course of their employment, irrespective of the fault of any party; also full provision for securing safety in places of employment; full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injury; full provision for adequate insurance coverage against liability to pay or furnish compensation; full provision for regulating such insurance coverage in all its aspects, including the establishment and management of a State compensation insurance fund; full provision for otherwise securing the payment of compensation; and full provision for vesting power, authority and jurisdiction in an administrative body with all the requisite governmental functions to determine any dispute or matter arising under such legislation, to the end that the administration of such legislation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character; all of which matters are expressly declared to be the social public policy of this State, binding upon all departments of the State government.

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GET /eSCL/ScannerStatus HTTP/1.1
Host: localhost
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State of California

GOVERNMENT CODE

Section 11135

11135. (a) No person in the State of California shall, on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, or sexual orientation, be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state. Notwithstanding Section 11000, this section applies to the California State University.

(b) With respect to discrimination on the basis of disability, programs and activities subject to subdivision (a) shall meet the protections and prohibitions contained in Section 202 of the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and the federal rules and regulations adopted in implementation thereof, except that if the laws of this state prescribe stronger protections and prohibitions, the programs and activities subject to subdivision (a) shall be subject to the stronger protections and prohibitions.

(c) The protected bases referenced in this section have the same meanings as those terms are defined in Section 12926.

(d) The protected bases used in this section include a perception that a person has any of those characteristics or that the person is associated with a person who has, or is perceived to have, any of those characteristics.

(Amended by Stats. 2016, Ch. 870, Sec. 4. (SB 1442) Effective January 1, 2017.)

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California Code, Labor Code - LAB § 4600

Current as of January 01, 2023 | Updated by FindLaw Staff

(a) Medical, surgical, chiropractic, acupuncture, licensed clinical social worker, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury shall be provided by the employer. In the case of the employer's neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the worker's injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of the employee's own choice or at a facility of the employee's own choice within a reasonable geographic area. A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allowed by subdivision (c) of Section 4604.5.

(d)(1) If an employee has notified the employee's employer in writing prior to the date of injury that the employee has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including the employee's medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of

Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee is entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee is entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e)(1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician, the employee is entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time the employee is given notification of the time and place of the examination.

(f) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, the employee shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(g) If the injured employee cannot effectively communicate with the employee's treating physician because the employee cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of the employee's injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or 5307.8. The employer is not liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

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Guide to Cumulative Trauma Disorders (CTDs)

Cumulative trauma disorders (CTDs) are injuries of the musculoskeletal system—including the joints, muscles, tendons, ligaments, nerves, and blood vessels that are often grouped together as CTDs, Repetitive Stress Injury (RSI), overuse syndrome, and repetitive motion disorders. CTDs are the largest work-related health problem in the U.S. CTD symptoms develop from the accumulation of repeated small injuries or stresses to our musculoskeletal system. CTD is not disease but a response to excessive or repeated demands on our body without enough time to recover before adding more stress. This article explains some of the concepts of CTD, what can cause CTD and how CTD causes symptoms. There are links to articles on our site many common CTDs as well as links to anatomy and function articles for the subject injuries.

- **Cumulative:** Repeated small injuries add up to a larger injury or syndrome
- **Trauma:** An injury to the body from a physical cause.
- **Disorder:** A problem with normal body functions. Syndromes are a group of signs or symptoms—like pain, tingling or weakness—that are linked by a common anatomical history.

Contents [hide]

Causes of Cumulative Trauma Disorders

CTDs are usually caused by a combination of risk factors:

- repetitive motions, that is making the same motion over and over like hammering a nail
- motions using force like pulling, pushing, lifting, and gripping
- awkward posture or body positions that are unnatural resting positions

- holding the same body position without moving or resting for long periods
- mechanical compression of soft tissues in the hand against hard edges or ridges: like tools or objects that press against the palm
- fast movement of body parts like swinging your arms
- vibration, especially in cold conditions, like using vibrating hand tools
- mental stress can cause muscles to tighten and restrict blood flow
- not enough recovery time with overuse like rest breaks or days off. This also increases other CTD risk factors.

CTDs which usually affect the arm and hands:

- carpal tunnel syndrome
- wrist tendonitis
- ulnar nerve entrapment
- epicondylitis (elbow)
- shoulder tendonitis
- hand-arm vibration syndrome

Common symptoms of CTDs include pain and swelling of the affected body part. Although back injuries are not considered CTDs, they often result from similar risk factors as CTDs. Some work and play activities have more risk factors than others. However, it's possible to reduce your risks and prevent CTDs. We've said overuse can cause problems, but what's really happening? Muscle Tension + Repetitive Motion + Over Use + Incorrect or Static Posture = CTD

Muscle Tension

To work properly, the body and its parts need a steady blood supply, rich in oxygen and nutrients. Cutting off or reducing the blood supply injures body tissues. When muscles are tense, they squeeze off the blood supply which is their source of energy and fuel. Muscles can get energy without oxygen however, the process produces lactic acid, a potent pain causing chemical. As the pain gets worse, the muscles keep tightening to protect the injured area—slowing down the blood supply even further. When nerves don't have enough blood plus the area is being squeezed by tense muscles, the nerves begin to tingle (that pins and needles feeling) or even go numb.

Repetitive Motion

Repetitive motion injuries cause tissue damage from repeated trauma—like writing, painting or typing. Almost any activity that produces repeated small trauma to an area of soft tissue—tendons, nerves, muscles—can lead to CTD. Trauma happens when muscles and joints perform the same movement over-and-over.

Over Use

Using muscles and joints after they're tired increases the chances of injury. When muscles or tendons are overloaded or overworked they don't get enough rest and don't have a chance to fully recover.

Incorrect or Static Posture

Incorrect standing and sitting postures put abnormal stress on the body causing pain and stiffness. Our joints are made to move—even correct posture held for too long is considered overuse.

Types of Cumulative Trauma Disorders

CTDs are basically disorders of tendons—which are part of the muscles—or nerves.

Tendon Disorders

Tendons are fibrous tissue that connect muscles to bones. Tendon disorders and their protective coverings, called synovial sheaths, are the most common CTDs. CTD symptoms include:

- a dull ache over the inured tendon
- tenderness when touched
- discomfort with certain movements
- disabling pain with repeated injury without treatment

Common tendon CTDs:

- **Tendonitis** is inflammation in the tendon caused when a muscle/tendon is used repeatedly. With normal use, the small fibers that make up tendons get small tears our body can easily repair. With continued overuse and without enough time to recover, the tears aren't able to completely heal. Tendons of the wrists, elbows and shoulders are most often affected. Risk factors at work or play that cause tendonitis include:
  - repetition
  - force
  - awkward or static posture
  - over-extension (excessive stretching) of muscles
  - fast movements
  - vibration

  Without enough rest to allow injured tissues to heal permanent damage can result.

- **Tenosynovitis** is a general term for irritation of the tendon's synovial sheath caused by unnatural positions, force or pressure, along with other CTD risk factors. Irritation stimulates the sheath to produce too much synovial fluid. The fluid accumulates causing the sheath to swell and be painful. Other symptoms include tenderness, cracking sounds, and often the loss of some function in the affected body part. A poorly arranged work station, poorly designed tools, and even bad work habits are causes tenosynovitis.

- **Stenosing tenosynovitis** is a form of tenosynovitis. Tightening of the tendon's synovial sheath is caused when the surface of the tendon gets irritated, rough, and swollen. Repetitive motions that put stress on the tendons, such as twisting of the hand and forceful gripping, cause abnormal thickening of the sheath and constriction of the tendons.

- de Quervain's tenosynovitis is from chronic friction between the two tendons in the thumb and the sheath they share. de Quervain's is the most recognized type of stenosing tenosynovitis. The thumb motion is restricted by the swollen tendons. Jobs with a high rate of de Quervain's include buffers/grinders, sewers and cutters, packers, and housekeepers.

- **Rotator cuff tendonitis**, the most common shoulder tendon disorder, is often associated with jobs that require the elbow to be in an overhead position for long periods of time. This position puts stress on the shoulder tendons causing tearing and swelling of the rotator cuff tendons. Repeated overhead motions cause thickening of the tendons and the tissues of the arm sockets. This can lead to "frozen shoulder" syndrome, which may include severe pain and the loss of shoulder function.

- **Ganglionic cysts** are also a tendon sheath disorder. A bump on the wrist forms under the skin from the sheath swelling up with synovial fluid from repetitive motion, such as prolonged typing or keyboard use.

- **Golfer's elbow** (medial epicondylitis) is inflammation of the epicondyle of the humerus in the elbow caused by repeated or forceful rotation of the forearm while bending the wrist at the same time. Epicondylitis is common in construction jobs and assembly work.

- **Tennis elbow** (lateral epicondylitis) is inflammation of the extensor tendons that attach to the outside of the elbow. It's caused by rapid over-arm motions like throwing. Athletes aren't the only ones affected. Most cases are caused by job-related cumulative trauma.

- Trigger finger happens when the tendon sheath of a finger is so swollen that the tendon becomes locked in the sheath. The ring and middle finger are most often affected. Trigger finger is usually caused by using tools with handles that have hard edges or ridges, and/or repetitive forceful gripping. The pain is not usually severe, but moving the finger causes snapping and jerky movements.

- **Bursitis** is inflammation of the bursae, small flat sacs filled with synovial fluid that prevent friction between tendons and muscles over bony areas like our shoulders, elbows, and knees. A tendon that gets rough from overuse irritates the bursa next to it causing the bursa to swell. Shoulder bursitis can make it hard to move the shoulder and limit movement.

Nerve Disorders

Pressure on the nerves pressing against hard edges or of work surfaces, tools, or nearby bones during repeated activities can result in cumulative trauma disorders of the nerve. The most common type of nerve CTDs:

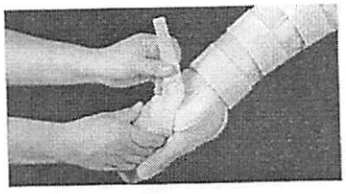
- Carpal tunnel syndrome (CTS) is an increasingly common CTDs. CTS refers to compression of the median nerve as it passes the carpal tunnel in the wrist. Any condition that increases the contents or decreases the size of the carpal tunnel can compress the median nerve. Jobs that combine high force, high repetition, awkward hand posture and little rest—like typing, assembly work, packing, bricklaying, sewing, and cutting—are at high risk for CTS. Symptoms of CTS include numbness, burning, and tingling in the first 3 ½ digits. If left untreated, symptoms can become much worse and result in the loss of grip strength, clumsiness, increased pain at night, and possibly permanent loss of hand function.

- **Raynaud's syndrome** is also referred to as "vibration white finger" or "hand-arm vibration syndrome." This condition is caused by forceful gripping and/or long-term use of vibrating tools like hand-held power drills, power saws, nail guns, chipping hammers, and rotary hammer drills. Using vibrating tools in cold temperatures increases the risk of Raynaud's syndrome. Symptoms include numbness and tingling in the fingers, skin that turns pale and cold, and ultimately loss of feeling and muscle control in the fingers and hands.

- **Thoracic outlet syndrome** (TOS) involves the compression of nerves from the spine and blood vessels from the heart that go to the muscles in the arm. TOS is caused by doing overhead tasks for long periods of time. Symptoms of thoracic outlet syndrome include numbness in the fingers, a weakened wrist pulse and feeling like one's arm "is asleep." Thoracic outlet syndrome is often mistaken for being carpal tunnel syndrome.

- **Other nerve entrapment syndromes.** Repetitive motion of the upper extremities can also entrap the median, ulnar, and radial nerves in other areas. **Pronator teres syndrome** involves entrapment of median nerve in the forearm. **Cubital tunnel syndrome** involves entrapment of ulnar nerve from outside pressure over the cubital tunnel at the elbow. **Radial tunnel syndrome** refers to entrapment of the radial nerve by the extensor muscles of the forearm.

Treatment of Cumulative Trauma Disorders



If you're diagnosed with a CTD, there are many conservative, non-surgical treatments to relieve discomfort from overuse. Splints may be recommended as an early treatment to protect and rest sore areas. Anti-inflammatory medicines are often used along with physical therapy like ice packs, ultrasound, or electrical stimulation. Special exercises help tissues move safely while they heal. Assess both your work and recreational activities to figure out if they are adding to your problem. Keep in mind that tension restricts the flow of blood causing muscles and nerves not to get enough oxygen and nutrients, aggravating the symptoms of CTD. Resting the injured area during work and play can relieve tension and allow recovery.

- Relax and pace yourself
- Take breaks often
- Don't be a stiff when you sit and stand
- Switch up work tasks; Cross train sports activity
- Change or correct your work or play areas
- Avoid caffeine and tobacco

Correct Posture and the Neutral Spine Position

Posture has a big role in CTDs. Slouching the spine or leading with your head puts your body off balance causing your arms and legs to be stretched or bent in awkward positions. The neutral spine position maintains the three natural curves of the spine:

- the inward curve of the neck **(cervical)** region
- the outward curve of the mid back **(thoracic)** region
- the inward curve of the lower back **(lumbar)** region.

Too much curvature or straightening in either the neck or lower back takes the spine out of its neutral position and increases the risk of injury. To prevent injury:

- Instead of leading with your head, rotate the upper body forward at the hips.
- Instead of slouching, rotate your upper body forward at the hips.
- Instead of bending or lifting with a bent lumbar spine, rotate your upper body forward at the hips.

Basic Guide for Sitting Posture

Sitting with a neutral alignment of the spine is also important. Sit in a comfortable chair designed to encourage correct sitting posture. Don't slouch; sit back in your seat against the back of the chair. Bending your head down strains your neck and affects nerves and arteries that go down into your arms. Relax your shoulders with your elbows, hips and knees bent at a right angle. Avoid pressure to the back of your knees. Keep your feet flat on the floor or support them on a foot rest. Don't sit still for long periods. Staying in one position causes muscle fatigue and tension. Take breaks often; get up and stretch.

Cumulative Trauma Disorders by Body Area

ElbowLateral EpicondylitisMedial Epicondylitis Radial Tunnel Syndrome Cubital Tunnel Syndrome

Neck
    Thoracic Outlet Syndrome
Shoulder (Anatomy and Function)
    Impingement Syndrome
Wrist and Hand
    Intersection Syndrome
    DeQuervain's Tenosynovitis
    Guyon's Canal Syndrome
    Trigger Finger and Thumb

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DISCUSSION

1. Permanent Total Disability

Defendant argues primarily that the holding in *Fitzpatrick* is binding authority **[*22]** that precludes a finding of permanent and total disability in accordance with the **[**73]** fact. (*Fitzpatrick, supra 27 Cal. App. 5th 607.*) Defendant argues that the court is limited to finding permanent total disability in accordance with applicant's assigned whole-person impairments, and not pursuant to applicant's work restrictions, which preclude him from gainful employment. Prior to analyzing the facts of this case, I must first clarify what the correct legal standard is for a finding of permanent and total disability in accordance with the fact.

A. Per the Permanent Disability Rating Schedule, and pursuant to *section 4660*, permanent total disability must be found where there is a total loss of future earning capacity.

Since the enactment of workers' compensation over 100 years ago, permanent total disability has essentially meant the same thing: the injured worker can no longer work.[3] (See *Postal Tel. Cable Co. v. Industrial Acci. Com., 213 Cal. 544, 547 (1931)* [Wherein the Supreme Court clearly defines permanent and total disability as follows: "The statute is plain, and recovery is allowed for total disability because the employee is unfitted by his injury to follow any occupation."]

The 2005 Permanent Disability Rating Schedules (PDRS) is issued pursuant to *section 4660* to rate disability for injuries occurring prior **[*23]** to January 1, 2013. (*§ 4660.*) The PDRS was created by the Administrative Director pursuant to *section 4660(e)* and expressly defines the term "permanent total disability" as follows:

> A permanent disability rating can range from 0% to 100%. Zero percent signifies no reduction of earning capacity, while 100% represents permanent total disability. A rating between 0% and 100% represents permanent partial disability. **Permanent total disability represents a level of disability at which an employee has sustained a total loss of earning capacity.** Some impairments are conclusively presumed to be totally disabling. (*Lab. Code, § 4662.*)

(2005 PDRS, pp. 1-2 to 1-3 (emphasis added).)[4]
[74]**

Per *section 4660(c)*, the PDRS "... shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." Thus, per the 2005 PDRS, where **[*24]** an injury causes total loss of earning capacity, applicant is permanently and totally disabled. We use the definitions of disability contained within the PDRS to assist in finding permanent and total disability in accordance with the fact under *section 4662*. This analysis has been used by the Supreme Court as early as 1953. (See *Thompson v. Long Beach, (1953) 41 Cal. 2d 235 [259 P.2d 649]* [using the definitions of disability within the PDRS to reach conclusions of permanent total disability under *section 4662*].)

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[3] This concept is not limited to permanent disability, but also includes temporary disability. (See ***Pacific Employers Ins. Co. v. Industrial Acc. Com., (1959) 52 Cal. 2d 417 [340 P.2d 622]*** [noting that where temporary partial disability results in complete loss of wages, the disability is deemed total].) As discussed *infra*, I realize this statement is a generalization and does not encompass the many nuances of finding total disability.

[4] I would note that the pre-SB 899, 1997 PDRS defined permanent and total disability using similar language:

> A rating can range from 0% to 100%. Zero percent signifies no reduction of ability to compete in an open labor market while 100% represents legal total disability. **Total disability does not mean that the employee cannot work, but rather represents a level of disability at which an employee would not normally be expected to be able to successfully compete in an open labor market.**

(1997 PDRS, p. 1-3 (emphasis added).)

In *Smith v. Industrial Acci. Com.*, the Supreme Court held that for purposes of determining permanent total disability when applying for Subsequent Injury Benefits Trust Fund benefits:

> We conclude, nevertheless, for the reasons hereinafter explained, that it is permissible and desirable to distinguish between a formula or rule-established "100 per cent disability" rating purposes, and actual total disability insofar as productive work or compensated employment is concerned.

(*44 Cal. 2d 364, 367-368.*)

By definition within the PDRS and as the concept has always been used throughout the history of workers' compensation, permanent total disability means that applicant is not able to go back to work.

B. Although the legal holding in *Fitzpatrick* is sound, the factual finding appears contradictory [*25] to the legal holding, and thus, the case is not persuasive.

Section 4662, in existence since 1913, specifies certain conditions that are conclusively presumed to constitute permanent total disability.[5] (§ 4662(a).) The section goes on to allow the Appeals Board to issue a finding of permanent total disability in accordance with the fact in those cases where the conclusive presumption does not apply. (§ 4662(b).)

In *Fitzpatrick*, the Third District Court of Appeal held that section 4662(b) does not provide an independent path to rebuttal of the rating provided for under the PDRS. (Fitzpatrick, supra at 622.) In sum, the court found that section 4660 is not limited to permanent partial disability. I have no reason to disagree with this legal holding; however, for reasons discussed below, it would appear that the factual analysis in *Fitzpatrick* was not complete. Thus, although *Fitzpatrick* is legally sound, the factual conclusion reached was an anomaly.

In *Fitzpatrick*, applicant's strict rating per the AMA Guides rated to 99% permanent partial disability. The Appeals Board upheld the finding of the WCJ, **[**75]** who issued an award of permanent total disability (100%) based upon the medical conclusion that applicant was completely precluded from returning to work and lost **[*26]** all future earning capacity. (See generally, *Fitzpatrick.*) It appears that as a matter of fact, the injured worker in *Fitzpatrick* was precluded from returning to work. (§ 5953 ["The findings and conclusions of the appeals board on questions of fact are conclusive and final and are not subject to review."].) Notwithstanding this fact, the Third District overturned the award of permanent total disability and instead found that the injured worker was only entitled to an award of 99% permanent partial disability. (See generally Fitzpatrick, supra.)

The legal holding in *Fitzpatrick* is that the Appeals Board must follow the PDRS in assigning permanent total disability, unless it is rebutted. The factual oversight in *Fitzpatrick* is that the PDRS expressly defines a complete loss of earnings capacity as constituting permanent total disability. The portion of the PDRS defining permanent total disability was not discussed by the *Fitzpatrick* court in reaching its conclusion[6] ; thus, it would appear that the holding is a factual anomaly.

To clarify, the Appeals Board must generally follow the PDRS in assigning permanent disability, unless it is otherwise rebutted. When assigning permanent total disability **[*27]** in accordance with the fact, per section 4662(b), the Appeals Board looks directly to the PDRS and the definition of permanent and total disability contained therein. Where applicant has lost all future earning capacity (and absent apportionment), the Appeals Board issues an award of permanent total disability. Such an award may reference section 4662, but in fact issues per the PDRS, which is created under section 4660. The *Fitzpatrick* holding is not persuasive and is limited to the analysis of facts therein.

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[5] Although section 4662 was enacted in 1937, it existed in a different form prior to that date. As noted in the *Fitzpatrick* holding: "For our purposes, section 4662 has remained substantively unchanged since its adoption in 1913." (Fitzpatrick, supra at 614.)

[6] The court defines permanent and total disability early in the opinion per the PDRS, but that definition is conspicuously absent from any further discussion. (*Fitzpatrick, supra* at *5.)

C. *Fitzpatrick* cannot be interpreted as precluding a finding of permanent total disability where applicant is unable to return to work, as such a finding is in direct conflict with every published case on the topic.

I have characterized the holding in *Fitzpatrick* as a factual anomaly; and thus, its application of the law to the facts of its case is not persuasive or controlling authority. I understand that defendant has presented a reasonable argument that the holding in *Fitzpatrick* is binding legal authority upon this court. To that extent, I find the legal conclusions reached in *Fitzpatrick* to be in direct conflict with binding published authority by other Courts of Appeal and by the Supreme Court. Given the direct **[*28]** conflict in authority presented, I choose to follow over 100 years of published case law and the common sense understanding of permanent total disability and the authority that the Appeals Board has to issue such awards that **[**76]** has existed since the beginnings of the workers' compensation system: if you cannot return to work because of your injury, you are permanently totally disabled.[7]

Perhaps most directly in conflict with *Fitzpatrick* is the decision in *Ogilvie*. (Compare *Fitzpatrick, supra*, with *Ogilvie v. Workers' Comp. Appeals Bd., (2011), 197 Cal. App. 4th 1262 [129 Cal. Rptr.3d 704, 76 Cal. Comp. Cases 624]*.) Pursuant to the holding in *Ogilvie*:

> [A]n employee may challenge the presumptive scheduled percentage of permanent disability prescribed to an injury by showing a factual error in the calculation of a factor in the rating formula or application of the formula, the omission of medical complications aggravating the employee's disability in preparation of the rating schedule, or by demonstrating that due to industrial injury the employee is **not amenable to rehabilitation and therefore has suffered a greater loss of future earning capacity than reflected in the scheduled rating**.

(*Ogilvie v. Workers' Comp. Appeals Bd., (2011), 197 Cal. App. 4th 1262, 1277 [129 Cal. Rptr. 3d 704, 76 Cal. Comp. Cases 624]* (emphasis added))

The third-prong in *Ogilvie* requires an applicant to prove two facts:

1. Applicant is not amenable to rehabilitation because **[*29]** of the industrial injury.

2. Applicant's non-amenability to rehabilitation has caused applicant to suffer a greater loss of future earnings capacity than reflected in the PDRS.

When you are completely precluded from return to work, you cannot be rehabilitated and you cannot earn. The third prong of *Ogilvie* is satisfied where there is complete medical preclusion from returning to work. To that extent, the holding in *Fitzpatrick* is in direct conflict with *Olgilvie*.

This same conclusion was reached by the Second District in *Borman*: "Here, we do not take issue with the WCALJ's conclusion that Borman could rebut the rating schedule's DFEC by offering vocational expert testimony showing 100 percent loss of earning capacity." (*Acme Steel v. Workers' Comp. Appeals Bd., (Borman) (2013) 218 Cal. App. 4th 1137, 1142 [160 Cal. Rptr.3d 712, 78 Cal. Comp. Cases 751]*.) The holding in *Fitzpatrick* appears in conflict with the holding in *Borman*. I will not construe the opinion in a manner that would create direct conflict between other published opinions.
[77]**

a. The calculation of disability within the PDRS Future Earning Capacity tables were not created, designed, researched, or otherwise applicable to permanent total disability awards.

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[7] I realize that this statement generalizes the legal and factual analysis, which includes many nuances and arguments that are raised in issuing a permanent and total disability award. For example, such a finding is subject to apportionment; however, here, no argument of apportionment was raised, as this was a presumptive injury per *section 3212*. (*§ 4663(e)*; see also, *Acme Steel v. Workers' Comp. Appeals Bd. (Borman), 218 Cal. App. 4th 1137 [160 Cal. Rptr.3d 712, 78 Cal. Comp. Cases 751]*.) The purpose of the statement is to provide clarity as to overarching purpose in awarding permanent and total disability.

Defendant is incorrect in construing *Fitzpatrick* as concluding that an injured worker is 100% permanent **[*30]** total disability only when the permanent partial disability is calculated to reach 100% under the various charts of the PDRS. Such a construction is contrary to the clear intent of the Legislature. It is clear that the charts of the PDRS that calculate permanent partial disability were not created to calculate total disability.

The Future Earning Capacity (FEC) adjustment table was created within the 2005 PDRS by statutory command:

> For purposes of this section, an employee's diminished future earning capacity shall be a numeric formula based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees. The administrative director shall formulate the adjusted rating schedule based on empirical data and findings from the Evaluation of California's Permanent Disability Rating Schedule, Interim Report (December 2003), prepared by the RAND Institute for Civil Justice, and upon data from additional empirical studies.

(*§ 4660(b)(2)*.)

The RAND Study referenced in the above statute is what created the FEC tables within the PDRS. The RAND study expressly excluded consideration of total disability cases:

> In **[*31]** a series of studies for the California Commission on Health and Safety and Workers' Compensation (CHSWC) the ICJ has examined the adequacy of permanent partial disability (PPD) benefits, the workers' compensation court system, and medical fee schedules.
>
> In this study, we focus on the system for evaluating permanent disabilities in California, the permanent disability rating schedule. **The rating schedule, which is used to determine eligibility for PPD benefits** as well as the amount of benefits, is at the center of legislative debates to reduce the costs of the workers' compensation system.

(Reville, Robert, et. al., Evaluation of California's Permanent Disability Rating Schedule, Interim Report (December 2003), available at https://www.dir.ca.gov/CHSWC/Reports/PermanentDisabilityRatingSchedule-InterimReport.pdf (emphasis added).)[8]

The sole statutory purpose of the RAND study was to aid the Administrative Director in creating the FEC table within the 2005 PDRS. As the RAND study **[**78]** only addresses permanent partial disability, the intent of the Legislature is clear. The FEC table is used in assigning permanent partial disability under the re-worked system of permanent disability determination. **[*32]** [9] The FEC table and remaining actuarial tables in the PDRS were never researched, created, conceived, or otherwise intended to be used as any calculation when applicant was permanently totally disabled.[10] [11]

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[8] "The appeals board may ... use as proof of any fact in dispute ... (f) All official publications of the State of California and United States governments." (*§ 5703*.)

[9] The 1997 PDRS and prior schedules assigned impairment based primarily upon work restrictions, which the Legislature felt to be too subjective. The work restrictions took into account both activities of daily living and the ability to work within a single chart. To make assignment of impairment more objective, the Legislature adopted the AMA Guides; however, the AMA Guides only includes consideration of activities of daily living in assigning impairment and expressly excludes consideration of ability to work from the analysis. Thus, the FEC adjustment table was created to accompany the AMA Guides.

[10] It is possible to reach a finding of 100% disability using the partial disability tables; however, to my knowledge, that method of reaching 100% has only affirmed a finding of complete loss of future earnings, which, in such cases, tends to be obvious. Where permanent partial disability reaches a combined 100%, the parties tend to be litigating the issue of apportionment. There may be a case where applicant is 100% under the partial disability tables, yet still able to earn, which may require additional analysis.

[11] The FEC table is inapplicable to injuries occurring on or after 1/1/2013, which replaced the FEC table with a base 1.4 modifier. (*§ 4660.1*.)

By definition contained within the PDRS and as used throughout workers' compensation for time immemorial, a complete loss of ability to work is permanent total disability. This is the factual point misanalysed in *Fitzpatrick*. The Third District states: "[B]y proceeding under section 4660, Fitzpatrick would have had the opportunity to rebut the 99 percent scheduled disability rating to show the appropriate rating is permanent total disability." (*Fitzpatrick, supra at 620.*) The Third District does not appear to understand that complete preclusion from returning to work is expressly defined as permanent total disability by the PDRS. You are not rebutting the PDRS at that point; you are following it.

The Oakland WCAB is based in the First District Court of Appeal. The holding in *Ogilvie* is binding upon this court. The dicta in *Dahl*, while not binding, is none-the-less persuasive that the First District agrees that a finding of 100% lost wages may permissibly constitute a finding of permanent total disability in accordance with **[*33]** the fact. (*Contra Costa County v. Workers' Comp. Appeals Bd., (Dahl) (2015) 240 Cal. App. 4th 746, 761 fn. 6 [193 Cal. Rptr.3d 7, 80 Cal. Comp. Cases 1119]* ["Notably, the two cases cited by *Ogilvie* which found claimants were unable to rehabilitate involved injuries that rendered the claimants unable to return to *any* type of gainful employment. (See *LeBoeuf, supra, 34 Cal.3d at pp. 239-240*; *Gottschalks v. Workers' Comp. Appeals Bd., supra, 68 Cal. Comp. Cases at p. 1716.*)"].) *Fitzpatrick* is also in direct conflict with the Second District's holding in *Borman*, which expressly concluded that applicant "... could rebut the rating schedule's DFEC by offering vocational expert testimony showing 100 percent loss of earning capacity." (*Borman, supra* at *218 Cal. App. 4th 1137, 1142.*) To that extent, the *Fitzpatrick* decision appears in direct conflict with **[**79]** well-established First District and Second District precedent and cannot be followed without further clarification from either the First District or the Supreme Court.

D. Applicant is permanently and totally disabled due to his industrial injury.

The proper legal standard for determining whether applicant is permanently and totally disabled is whether applicant's industrial injury has resulted in applicant sustaining a complete loss of future earning capacity. (*§§ 4660, 4662(b)*; see also 2005 PDRS, pp. 1-2, 1-3.) Substantial evidence shows that applicant is not amenable to vocational rehabilitation and is precluded from gainful employment solely **[*34]** because of his 2005 industrial injury. Accordingly, applicant is permanently and totally disabled.

A finding of permanent total disability in accordance with the fact (that is complete loss of future earnings) can be based upon medical evidence, vocational evidence, or both. Medical evidence of permanent total disability could consist of a doctor opining on complete medical preclusion from returning to work. For example, in cases of severe stroke, the Appeals Board has found that applicant was precluded from work based solely upon medical evidence. (See i.e., *Reyes v. CVS Pharmacy, (2016) 81 Cal. Comp. Cases 388* (writ den.); see also, *Hudson v. County of San Diego, 2010 Cal. Wrk. Comp. P.D. LEXIS 479.*)

A finding of permanent total disability can also be based upon vocational evidence. In such cases, applicant is not precluded from working on a medical basis, per se, but is instead given permanent work restrictions. Depending on the facts of each case, the effects of such work restrictions can cause applicant to lose the ability to compete for jobs on the open labor market, which results in total loss of earning capacity. Whether work restrictions preclude applicant from further employment requires vocational expert testimony.

Although here, the AME does opine that applicant is precluded from working, **[*35]** this does not appear to be a medical preclusion and is instead reflective of the AME agreeing with the results of the functional capacity evaluation and agreeing with applicant's vocational expert analysis. Applicant has undergone multiple functional capacity evaluations. Those evaluations clearly show that applicant lacks any capacity to work in the open labor market.

Applicant presented substantial evidence in the form of functional capacity evaluations and vocational expert testimony that establishes that the physical restrictions placed on him by the 2005 industrial injury preclude him from gainful employment. Applicant has lost all future earning capacity because of his industrial injury. By definition contained in the PDRS, applicant is permanently and totally disabled.

I decline to follow the opinions of defendant's vocational expert, Ms. Tincher, as her opinions are not based upon substantial evidence. Ms. Tincher's opinions are essentially an opinion on vocational apportionment.

Ms. Tincher initially opined that the apportionment assigned by the medical-legal evaluators was not applicable to applicant's DFEC. (Defendant's Exhibit A, **[**80]** supra at p. 30.) Ms. Tincher stated: "It is **[*36]** not possible to apply apportionment to work restrictions[.]" (*Ibid.*) Then, in her final report, Ms. Tincher does not apply apportionment explicitly. (See generally, Defendant's Exhibit C, *supra*.) What Ms. Tincher does is to modify applicant's work restrictions to create work restrictions that Ms. Tincher believes are a result of the industrial injury. Instead of analyzing applicant's actual restrictions as provided by the functional capacity evaluator, Ms. Tincher created a fictional person with semi-sedentary abilities. As explained in *Dahl, supra*, this is not a proper analysis. Rehabilitation is an individualized assessment. We do not create skilled fictional workers for comparison. As Ms. Tincher's opinion is not based on the facts of this case, her opinion cannot be followed.

2. Apportionment

A. Applicant's permanent total disability is entirely attributable to the industrial injury, without apportionment.

Labor Code section 4663 requires any report addressing permanent disability to also address apportionment of disability. Defendant carries the burden of proof on apportionment. (§ 5705.) Apportionment of permanent disability must address causation of disability and must constitute substantial evidence. **[*37]** (*Escobedo v. Marshalls (2005) 70 Cal. Comp. Cases 604, 611, 620-621 (Appeals Board en banc)*.)

Causation of disability is not to be confused with causation of injury. (*Id. at 611*.) This concept appears to confuse many in the workers' compensation community. To determine whether you are apportioning correctly, you must define what the rated disability is, and then determine what the causes of that disability are. As discussed by our Supreme Court, permanent disability has multiple forms.

> Permanent disability is understood as the irreversible residual of an injury. (Citation.) A permanent disability is one which causes impairment of earning capacity, impairment of the normal use of a member, or a competitive handicap in the open labor market. (Citation.) Thus, permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future earning capacity.

(*Brodie v. Workers' Comp. Appeals Bd. (2007) 40 Cal. 4th 1313, 1320 [57 Cal. Rptr.3d 644, 456 P.3d 1100, 72 Cal. Comp. Cases 565]* (*Brodie*) (citations and quotations omitted).)

In this case, our first step in determining apportionment is to define applicant's disability. Here, applicant's disability is complete impairment of earning capacity due to work restrictions. Next, we have to determine what the causes of applicant's work restrictions are.

Here, the parties stipulated that applicant was able to earn $921.60 **[*38]** per week at the time of injury. (MOH Day 1, *supra* at p. 2, lines 32-35.) Post-injury, applicant cannot earn income. It is true that applicant is not a native English speaker and **[**81]** that he suffered a prior injury to his low back, and had some pre-existing psychological issues. However, all of these non-industrial issues existed on the day that applicant was attacked at work. With all of these non-industrial issues in place, applicant was able to earn $921.60 per week. In order to apportion the vocational disability, defendant needs to prove that something other than the industrial injury is causing applicant to lose all earnings today.

Defendant has provided evidence indicating that applicant had non-industrial issues that put applicant at greater risk of sustaining total permanent disability. Defendant has not provided evidence showing that these non-industrial issues are the cause of the total permanent disability. This is not sufficient to find apportionment.

> A corollary of the no-fault principles of workers' compensation is that an employer takes the employee as he finds him at the time of the employment. (Citations.) Thus, an employee may not be denied compensation

merely because his **[*39]** physical condition was such that he sustained a disability which a person of stronger constitution or in better health would not have suffered.

(*South Coast Framing v. Workers' Comp. Appeals Bd. (Clark) (2015) 61 Cal. 4th 291, 300 [188 Cal. Rptr. 3d 46, 349 P.3d 141, 80 Cal. Comp. Cases 489]* (citations and quotations omitted).)

Here, the finding of permanent and total disability is based on applicant's work restrictions flowing from the industrial injury. The work restrictions that are in place today did not exist prior to the industrial injury and applicant has provided expert evidence that the work restrictions were caused as a result of the industrial injury. Defendant has provided no evidence to prove any non-industrial cause of the restrictions. Accordingly, apportionment of applicant's disability is 100% industrial.

The industrial injury has completely precluded applicant from earning the $921.60 per week that he was otherwise earning prior to the industrial injury and notwithstanding all of the non-industrial factors affecting applicant's employability, including any prior permanent disability that may have existed at the time of the injury. No evidence exists to find that applicant's present work restrictions are apportionable to any prior injury. In fact, defendant's own expert says that it is not possible to determine **[*40]** such apportionment. (Defendant's Exhibit A, *supra* at p. 30 [Wherein Ms. Tincher stated: "It is not possible to apply apportionment to work restrictions[.]"].)

Defendant argues that it has offered evidence of non-industrial causes of applicant's inability to work. (Petition for Reconsideration, September 13, 2019, p. 18, lines 2-3.) I disagree. Defendant has offered many arguments as to potential non-industrial causes of applicant's work restrictions. However, arguments are not evidence. (*Hamilton v. Lockheed Corporation (Hamilton) (2001) 66 Cal. Comp. Cases 473, 476 (Appeals Board en banc)*.) Defendant's arguments must be supported by expert evidence finding vocational apportionment. The evidence of **[**82]** apportionment to applicant's work restrictions was succinctly stated by defendant's own vocational expert: "It is not possible to apply apportionment to work restrictions[.]" (Defendant's Exhibit A, *supra* at p. 30.)

Applicant sustained an industrial injury. He obtained surgery, which resulted in a failed back surgery. Applicant's back surgery caused significant restrictions on applicant's ability to work, which has the actual effect of precluding applicant from any gainful employment. Applicant cannot rehabilitate due to the effects of the failed back surgery. Applicant has proven causation **[*41]** of his permanent total disability is industrial in nature. Defendant's own evidence precludes a finding of apportionment in this case.

Having fully reviewed the medical file and the vocational reporting, I am convinced that applicant's inability to work post-injury is entirely due to the industrial injury. Accordingly, I issued a finding of 100% permanent total disability without apportionment.

i. Medical Apportionment

Applicant's rated disability in this case is the work restrictions caused by the injury and not the physical impairments caused by the injury. Accordingly, apportionment is a vocational analysis as to what is causing the restrictions and not a medical analysis. To that extent, the discussion of *Hikida* in the Opinion on Decision is admittedly dicta. However, even if we analyzed the work restrictions under the medical apportionment, such apportionment is legally impermissible based upon the holding in *Hikida*.

The parties presumably choose an agreed medical evaluator (AME) because of the AME's expertise and neutrality. (*Power v. Workers' Comp. Appeals Bd. (1986) 179 Cal. App. 3d 775, 782 [224 Cal. Rptr. 758, 51 Cal. Comp. Cases 114]*.) The Appeals Board will follow the opinions of the AME unless good cause exists to find his or her opinion unpersuasive. (*Ibid.*) Here, the AME found 10% apportionment **[*42]** of applicant's disability to the prior 1989 back injury. However, Dr. Charles went further and upon questioning he explained that applicant's present disability actually arises from the failed back surgery, which was necessitated by the 2005 industrial injury.

As was explained in *Hikida*:

> Our review of the authorities convinces us that in enacting the "new regime of apportionment based on causation," the Legislature did not intend to transform the law requiring employers to pay for all medical treatment caused by an industrial injury, including the foreseeable consequences of such medical treatment. Pre-2004 law constraining the application of apportionment in the award of permanent disability benefits was based primarily on the interpretation of former sections 4663 and 4750, which were eliminated or fundamentally altered by the 2004 amendments. The long-standing rule that employers are responsible for all medical treatment necessitated in any part by an industrial injury, including new injuries resulting from that medical treatment, **[**83]** derived not from those statutes, but from (1) the concern that applying apportionment principles to medical care would delay and potentially prevent an injured employee **[*43]** from getting medical care, and (2) the fundamental proposition that workers' compensation should cover all claims between the employee and employer arising from work-related injuries, leaving no potential for an independent suit for negligence against the employer. Nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the consequences of medical treatment without apportionment.

(*Hikida, supra at 1262-1263.*)

The decision in *Hikida* was further bolstered by the Supreme Court's discussion of the ramifications of workers' compensation medical treatment in *King v. CompPartners*: "[E]mployers are ultimately responsible for paying benefits to workers who suffer injuries as a result of the utilization review process." (*5 Cal. 5th 1039, 1060)* Employers may not claim apportionment where applicant's condition has worsened because of the provision of medical treatment in the workers' compensation system.

As applicant's disability is a result of failed back surgery, which was necessitated by the 2005 industrial injury, and pursuant to the holding in *Hikida*, applicant's disability is not apportionable. No good cause exists to disregard the opinions **[*44]** of the AME on the issue of apportionment. Accordingly, even if we looked at the medical apportionment, applicant's permanent total disability cannot be apportioned on a medical basis.

ii. ***Section 4664***

The requirements for proving apportionment per *section 4664* are as follows:

> First, the employer must prove the existence of the prior permanent disability award. Then, having established by this proof that the permanent disability on which that award was based still exists, the employer must prove the extent of the overlap, if any, between the prior disability and the current disability. Under these circumstances, the employer is entitled to avoid liability for the claimant's current permanent disability only to the extent the employer carries its burden of proving that some or all of that disability overlaps with the prior disability and is therefore attributable to the prior industrial injury, for which the employer is not liable.

(*Kopping v. Workers' Comp. Appeals Bd. (2006) 142 Cal. App. 4th 1099, 1115 [48 Cal. Rptr. 3d 618].*)

The primary issue here appears to be a lack of the prior award in evidence or in the board's file to review. As this was a case settled in the early 1990's, the prior award is not in the court's file, and thus I cannot take judicial notice of it. The awards **[*45]** are not in evidence, thus defendant failed its burden of proof as to apportionment per section 4664.
[84]**

The next issue for apportionment under section 4664 is the use of different rating schedules as between the dates of injury. It does not appear that defendant has provided evidence of overlap. Defendant appears to concede this argument in its petition, which ultimately appears to argue for apportionment only under *section 4663*. (Petition for Reconsideration, supra at p. 22, lines 19-22.)

I would further note that it appears the 1989 back claimed settled via Compromise and Release. Although it is impossible to tell as the settlement document has not been provided, it would appear unlikely that the Compromise

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California: Common Mistakes Physicians Make in Their MMI Reports

The opinions expressed in this article are those of the individual author and are not those of the Department of Industrial Relations, Division of Workers' Compensation or of the WCAB.

The following are three examples of reports from treating and evaluating physicians whose conclusions did not constitute substantial medical evidence. Each flawed MMI report resulted in a workers' compensation judge's rejection of a settlement and the requirement that the record be further developed in accordance with *McDuffie v. Los Angeles Metropolitan Transportation Authority* [(2002) 67 Cal. Comp. Cases 138 (Appeals Board en banc decision)]. These examples are excerpted from the upcoming 2020 Edition of *The Lawyers' Guide to the AMA Guides and California Workers' Compensation*, where a total of ten examples are given. You can pre-order the 2020 Edition today on the LexisNexis Store.

EXAMPLE #1: A long-term assembly worker trips and falls on the employer's multi-building campus and injured her right arm and shoulder. The diagnosis is right humeral head, proximal humeral head four-part fracture. She has two surgeries: the first one is a SLAP debridement (superior labrum from anterior to posterior, and then a release for adhesive capsulitis or a frozen shoulder. There is no MMI report from a treating physician, so a panel QME is selected through her counsel.

In his physical examination section of the MMI report, the QME states: "Upper extremity motor function shows that deltoid 3 to 4/5, biceps 4/5, triceps 4/5." He then correctly provides the six ranges of motion of the right injured shoulder. Under his examination section, the QME writes: "Right shoulder strength is 3/5 throughout shoulder girdle."

Under the section "Impairment Rating," the QME states: "Flexion 80 degrees, 7% UE Fig. 16-40; Extension 25 degrees, 3% UE, Fig. 16-43, Abduction 80 degrees, 5% UE, Fig. 16-43, Adduction 0% UE, External rotation 1% UE, Fig 16-46; Total 16% UE, conversion table; Table 16-3 10% WPI; chronic pain, add 3% WPI; Grand Total = 13% WPI."

The QME then states under Future Medical: "Claimant's right shoulder joint condition is likely beyond the remedial capability of arthroscopic technique. Right shoulder joint

pathology may require total shoulder replacement."

What mistake did this QME make? First of all, the value of the glenohumeral joint is 36% WPI pursuant to Table 16-18. This Applicant is a candidate for a total shoulder replacement based on the QME's findings. Therefore, a 13% WPI rating empirically is inadequate and inaccurate. What this means is that the panel QME failed to apply Table 16-35, which is manual muscle strength testing along with the range of motion measurements he did find later in his report. He provided the raw data needed to rate the manual muscle strength loss, but he did not carry those objective findings forward to his discussion of permanent impairment. The raw data was provided by the physician and Table 16-35 is easily applied.

The AMA *Guides* indicate that loss of motion combined with loss of strength should not be combined unless there is a pathophysiological reason to do so that is explained by a physician and the patient is not inhibited from using maximum effort.

In this case, both range of motion and strength loss are applicable because of the severe degeneration of the Applicant's entire right shoulder joint four years after her specific injury of April 16, 2010. She was examined by the QME in August 2014 by which time the devastating effect of the four-part proximal humeral head fracture with two shoulder surgeries including a SLAP debridement and release of adhesive capsulitis after a frozen shoulder joint had occurred. The Applicant had multiple fractures of her humeral head with post-traumatic arthritis and changes to her glenohumeral joint. This involves separate pathophysiological causes that resulted in her loss of strength and loss of shoulder motion.

Accordingly, the Applicant has the following permanent disability based on a review of the entirety of the QME report:

Based on the conclusions of the QME as to loss of range of motion:

Right shoulder Flexion 80 degrees: 7% UE

Extension 25 degrees: 3% UE

Abduction 80 degrees: 5% UE

Adduction normal: 0% UE

External Rotation: 1% UE

Internal Rotation: 0% UE

Total UE for loss of motion: 16% UE

Grade 3/5 muscle strength testing Table 16-35:

Flexion: 30% of 24 UE = 7% UE

Extension: 30% of 6 UE = 2% UE

Abduction: 30% of 12 UE = 4% UE

Adduction: 30% of 6 UE = 2% UE

Internal Rotation: 30% of 6 UE = 2% UE

External Rotation: 30% of 6 UE = 2% UE

Total UE for muscle strength loss: 19% UE

19% UE strength loss **combined** 16% UE range of motion = 32% UE = 19% WPI plus 3% for pain related impairment = 22% WPI.

The final rating is as follows:

16.02.01.00 – 19 + 3% pain = 22 – [7] 30 – 221F – 30 – 35% Final PD

The original rating was only 10% WPI for the range of motion loss, plus 3% WPI for pain related impairment. The more accurate rating is 22% WPI that includes the 3% WPI pain add-on. Counsel should be aware that the loss of motion and manual muscle strength ratings are in UE and then combined using the CVC, then converted to WPI, then the 3% WPI pain add-on is added to the 19% WPI. This rating is based on the 2005 permanent disability rating schedule instructions on page 1-11, which states in part:

> Multiple impairments such as those involving a single part of an extremity e.g. two impairments involving a shoulder such as shoulder instability and limited range of motion, are combined at the upper extremity level, then converted to whole person impairment and adjusted before being combined with other parts of the same extremity.

The justification of the 3% WPI pain add-on included consideration for the fact that the Applicant was severely restricted by the QME to the use of her right dominant arm. He

stated she is limited to: "semi-sedentary work; Right arm usage limited to light lift, less than 10 pounds and elevate shoulder to less than 80 degrees."

There are multiple takeaways in this example since shoulder impairments are complex and physicians do not carry over many objective ratable findings to the discussion of permanent impairment. Also, make sure physicians use upper extremity measurements for the range of motion and other upper extremity disorders and do not mix them up with WPI ratings for the same part of body.

EXAMPLE #2: 55-year-old packer for a glass manufacturer had a 3400-pound steel frame loaded with glass panels run over his left foot, resulting in a dislocated great toe. The Applicant had surgery to fuse the great toe's first interphalangeal joint [IPJ] with a reconstruction of the metatarsophalangeal joint [MPJ]. One year after the surgery, he returned to work, wearing an orthotic device on his left foot. In the MMI report from the treating podiatrist, it is noted that the Applicant walks with an "antalgic gait." A walk-through Stipulations With Request for Award was submitted to a judge for approval with a 0% permanent disability.

In his rejection of the 0% permanent disability proposed settlement, the judge indicated in the Order Suspending Action on the settlement that the treating physician's report "does not provide an evaluation for the gait impairment pursuant to Table 17-5 or any other alternative rating for a dislocated great toe on the left foot that has a surgically fused joint." The judge recommended that the Applicant obtain an opinion from a panel qualified medical evaluator in accordance with Labor Code § 4062.1, the procedure for an unrepresented injured worker to obtain such an evaluation,

In fact, the Applicant did select a panel QME in podiatry and the QME listed the following objective findings on examination: "Ankylosis and arthritis 1st IPJ, hallux limitus 1st MPJ, muscle weakness, atrophy calf, and gait derangement." The QME report has a very detailed description of the Applicant's residual left foot conditions as a result of this very serious injury. The report constitutes substantial medical evidence and can be a model for any foot or ankle injury case. The QME's description of how and why he came up with a 10% WPI overall impairment rating is worth reading:

> The Applicant has paresthesia beginning at the anterior left ankle to the dorsum of his toes. Furthermore, he states he has paresthesia from the proximal 1st through 5th MPJ region distal to the tips of 1st through 5th toes. There was no pain with range of motion to the left 1st IPJ but there is complete ankylosis to the joint with no motion,

There was mild pain with range of motion with dorsiflexion to the right 1st MPJ but the joint motion is limited. That does not coincide with an arthritic joint causing pain to the 1st IPJ necessitating a fusion, But it is reasonable why he would be having pain at the 1st MPJ due to hallux limitus and jamming of the MPJ with dorsiflexion of the joint. It also makes sense why he had a steppage gait and avoids a normal heel to toe gait, therefore avoiding dorsiflexion of the 1st MPJ. His left foot is supinated and inverted because he is avoiding pressure to the medial forefoot. Therefore, he may have a nerve compression injury to the dorsal digital (superficial dorsal cutaneous) and plantar digital (medical plantar) nerves. His gait is altered secondarily because of muscle weakness, limited range of motion to the 1st MPJ, no motion to the 1st IPJ, and possible nerve pain.

Under objective factors, the QME stated: "Ankylosis and arthritis 1st IPJ, hallux limitus 1st MPJ, muscle weakness, atrophy calf, and gait derangement." The QME utilized range of motion, ankylosis, and atrophy from pages 530-552 and Tables 17-14, 17-30, 17-6 and 17-37 as follows:

Pages 533-538 and Table 17-14, range of motion toe impairment. The left 1st MPJ has mild limited range of motion rated at 1% WPI and the 1st IPJ (moderate to severe) o degrees range of motion rated at 2% WPI.

Pages 538-543 and Table 17-30, joint ankylosis toe. The 1st MPJ and IPJ have ankylosis with rating of 4% WPI.

Pages 530-531 and Table 17-6, muscle atrophy as measured to the calf with the right larger by 1 cm, rated at 1% WPI.

Pages 550-551 and Table 17-37, peripheral nerve injury, the medical plantar nerve to the great toe with rating 2% WPI.

Therefore, the total impairment rating is summed to (1+2+4+1+2) = 10% WPI, all based on the objective findings on examination.

The DWC Disability Evaluation Unit (DEU) rated the above factors as follows:

Left Greater Toe ROM/Ankylosis 10 C5 C 2 = 17 LE = 7% WPI

17.09.07.00 – 7 – [1.4] 10 – 460H – 13 – 16 PD (A)

Left Calf Atrophy: 3 LE = 1% WPI

17.09.01.00 – 1 – [1.4] 1 – 460F - 1 – 1 PD (A)

Left Medical Plantar Nerve – Peripheral Nerve: 5 LE = 2% WPI

17.01.04.0 – 2 – [1.4] 3 – 460H – 5 – 6 PD (A)

(A) 16 combined 6 combined 1 = 22% Final Permanent Disability

This case illustrates a number of things. Number one, it raises the question of how many cases like this slipped through the cracks and resulted in a 0% or extremely low permanent disability award if the judge was not paying attention to the medical evidence behind a proposed Award? This case was presented for approval by a judge on a walk-through basis. Number two, this case also illustrates that physicians are reluctant to use Table 17-2, the cross-usage chart that prevents pyramiding impairments such as "diagnosis based" with "atrophy." The QME in this case simply stated that using the cross-usage chart was not accurate in describing the devastating effect this injury has on the Applicant's ability to ambulate. Number three, this QME did not use station and gait impairments from Table 13-15 in Chapter 13, nor antalgic gait of up to 7% WPI from Table 17-5 since he felt the objective findings added up to more specific and more accurate impairment ratings. This case, after all, is a great toe injury and does not involve the entire foot or ankle.

EXAMPLE #3: A 27-year-old dishwasher at a restaurant on 11/14/13 lifts a heavy bin of dishes and has the acute onset of low back pain. Within one week, he retains counsel who sends him for treatment with a chiropractor. The chiropractor's MMI report rates 47% WPI while a panel QME in orthopedic surgery rates a 5% WPI. Both physician reports are wrong. Why?

The Chiropractor's MMI report includes some of the following factors:

The Applicant has normal gait; Sensation is decreased in the right lower extremity over the L4-S1 dermatome; Motor strength is decreased in the left quadriceps, hamstrings, tibialis anterior, peroneus longus, and extensor hallucis muscles (L4-S1 dermatomes); motor strength is decreased in the right peroneus longus and extensor hallucis muscles (L5-S1 dermatomes); Knee jerk and Achilles reflexes are decreased bilaterally.

Left Straight Leg Raise ranges to 10 degrees with pain radiating to the buttock; Right Straight Leg Raise ranges to 12 degrees with pain radiating to the buttock. Range of motion measurements are:

Lumbar Flexion: 12 degrees (Normal is 60+ degrees) WPI = 8%

Lumbar Extension: 9 degrees (Normal is 25 degrees) WPI = 5%

Lumbar Left lateral bend: 12 degrees (Normal is 25 degrees) WPI = 3%

Lumbar right lateral bend: 15 degrees (Normal is 25 degrees) WPI = 2%

TOTAL WPI FOR LUMBAR ROM: 18% WPI

Under Table 15-7 spinal disorders, he has disc herniations at two levels with degenerative changes and radiculopathy which is 7% plus 2% WPI under Sections IIC and IIF of Table 15-7.

TOTAL WPI FOR SPINAL DISORDERS Table 15-7: 9% WPI

He has radiculopathy in both lower extremities at multiple levels, under Tables 15-15-, 15-16, 15-18 he has Grade 4, 25% sensory and motor deficits at each level of L4, L5 and S1; with 9% LE, 9% LE, 5% LE for the left lower extremity; and a 25% sensory and motor deficits at each level of L4, 5, and S1 with 1% LE, 1% LE, 9% LE, and 5% LE for the right lower extremity. This totals 17% LE which is a 7% WPI.

TOTAL WPI FOR SENSORY AND MOTOR DEFICITS: 7% WPI

1/12/14 MRI LUMBAR SPINE:

L3-L4 broad based disc protrusion which causes stenosis of the canal; disc measurements are neutral 5.4 mm, flexion 2.7 mm, extension 2.7 mm;

L4-L5: Broad based disc protrusion which causes stenosis of the spinal canal

There is associated stenosis of the bilateral lateral recess with deviation of the visualized bilateral L5 transiting nerve roots. Neutral 4.0 mm, flexion 5.4 mm, extension 5.4 mm.

L4-L5 (sic) Broad-based disc protrusion which causes stenosis of the spinal canal. There is associated stenosis of the bilateral lateral recess with deviation of the visualized bilateral S1 transiting nerve roots. Neutral 4.0 mm, flexion 5.4 mm, extension 5.4 mm.

2/5/14 X-ray of the lumbar spine [by a reputable radiologist] reveals "Normal lumbar spine examination with no subluxation on flexion and extension.

3/10/13 CT of the lumbar spine [also from a reputable radiologist]:

L3-4: 1-2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing;

L4-5: 2-3 mm posterior disc bulge resulting in mild left neural foraminal narrowing; left facet joint has vacuum effect;

L5-S1: 3-4 mm posterior disc bulge resulting in mild right and mild to moderate left neural foraminal narrowing, mild canal stenosis,

4/4/14 EMG/NCV: Normal studies of the lower extremities with no acute or chronic denervation; no electrophysiological evidence of peripheral nerve entrapment.

The chiropractor then goes through two pages of his report applying the pain related impairment criteria in chapter 18 of the AMA *Guides* and goes through all of the activities of daily living criteria in Table 1-2 of the *Guides* and concludes there should be a 3% WPI pain add-on. The chiropractor goes on to apply an Epworth Sleep Study and puts the Applicant into a Class I of Table 13-4 and assigns a 5% WPI rating for a sleep disorder. He also adds another 8% WPI for emotional and behavioral impairments based on Table 13-4 of the *Guides*. He justifies doing the foregoing based on the "*Almaraz Guzman* case for a more accurate WPI rating." The chiropractor also concluded there is no apportionment of permanent disability to non-industrial factors.

The chiropractor's summary of impairments is:

Lumbar disc herniations at L4-5 and L5-S1 with degenerative changes: 9%

Lumbar spine loss of motion: 18%

Left lumbar radiculopathy (decreased motor strength): 8%

Right lumbar radiculopathy (decreased motor and sensation): 7%

Limitation of daily social and interpersonal functioning: 8%

Sleep impairment: 5%

Pain related impairment: 3%

TOTAL WHOLE PERSON IMPAIRMENT: 47%

This example is valuable because it assists counsel in finding the red flags that indicate specific problems with medical reports and to more closely scrutinize a physician's conclusions. The context of this report is that it was submitted to a trial judge at trial. A report from a panel QME in orthopedic surgery was also submitted into evidence, and this doctor concluded that the Applicant's lumbar spine injury is MMI with a DRE Category II 5% WPI and no apportionment of permanent disability to non-industrial factor. The trial judge asked another judge to read the treating physician's report because the trial judge felt there was "something fishy" about the chiropractor's report. What are the telltales of the red flags?

There are a number of factors that caught the attention of the reviewing judge. At the time of the MMI exam by his chiropractor, the Applicant was 28 years old (he was 27 on the date of injury), 5'11" and 266 pounds, which is about 70 pounds overweight. The second red flag was the physical examination section of the MMI report. The chiropractor indicated that the straight leg raising (SLR) test was positive at 10 degrees with the left leg and 12 degrees with the right leg. This is pure nonsense. A straight leg raise test is a very reliable test to determine if there is irritation of the sciatic nerve distribution from a herniated disc or other nerve compression phenomenon. Usually, with a frank disc herniation, the SLR is strongly positive at 60 degrees or more. A proper SLR test will follow the illustration on page 405 of the *Guides*. In addition, a proper examination would include both a supine SLR test and a sitting SLR test where the patient is sitting on the edge of an examination table and the physician brings the patient's leg from a gravity assisted level (the legs dangling off the table with the knees bent) to 90 degrees of extension for each leg. This result should be the exact same as for the supine SLR. SLR testing is a gold standard to prove the existence of nerve root irritation in clinical medicine and in social security disability cases involving the lumbar spine.

The next red flag in this case was the chiropractor's finding of muscle weakness and motor strength deficits for lower extremity dermatomes. The nerve conduction and EMG studies were normal. When there is a sensory and motor deficit as bad as this doctor claims there is, the electrophysiological testing would also be positive, especially when there is motor function impairment. The rule with nerve compression phenomenon is that sensory deficits occur first, then motor deficits if there is nerve damage. Once there are motor function deficits, then the nerve damage is permanent. An example of this is a person who has

developed "drop foot", which is evidence of permanent nerve damage along the sciatic-tibial-peroneal nerve distribution.

The next red flag is the MRI scan results for the lumbar spine. The MMI report "summarizes" the findings of the radiologist who purportedly read the MRI for the lumbar spine. What indicates that the MRI conclusions are bogus are the results of the CT scan that is discussed later in the MMI report. The MRI scan was performed less than 90 days from the date of injury. There is no way the degenerative changes mentioned in the MRI report is post traumatic. Usually with an acute injury such as what occurred in this case (the Applicant lifting a heavy bin of dishes), there would be one level of the spine, usually L4-L5 or L5-S1 that would show a herniation or disc bulge. There was nothing like that in this MRI.

The other problem with the MRI report is the radiologist indicating how many millimeters the "disc measurements" are. This is pure nonsense as well. The average diameter of the lumbar spinal canal is 13 mm. The statement for example that at L4-L5 the disc measurements are "neutral 4.0 mm, flexion 5.4 mm and extension 5.4 mm" is utter nonsense. It is hard to believe that flexion-extension MRI scanning was even performed. In fact, the gold standard to see if a patient has spondylolisthesis is to perform flexion-extension x-rays and not an MRI scan. A credible x-ray of the lumbar spine by another radiologist found no evidence of subluxation on flexion and extension x-rays. If the MRI radiologist is referring to what diameter of the lumbar spinal canal is remaining due to spinal stenosis, anyone with 4.0 mm or 5.4 mm left in the spinal canal space would have extreme difficulty to walk or bend. That type of spinal canal stenosis would require an emergent neural foraminal and central canal decompression surgery.

What gives this case away the most is the result of the CT scan of the lumbar spine which was conducted by a credible radiologist. The CT scan indicates that the Applicant has a 1-2 mm bulge at L3-L4, a 2-3 mm at L4-L5, and a 3-4 mm bulge at L5-S1. There is no frank nerve root impingement phenomenon. These findings are not unusual for a 27-year-old man who engages in heavy work and who is 70 pounds overweight. Expressed a different way, these findings are within normal limits for a man of this body habitus and age. The reference to "vacuum phenomenon at the facet joint" means the facet joint is degenerating, but the Faber test for

sacroiliac pain was negative.

Another red flag for this report is the fact that the chiropractor claimed to utilize *Almaraz-Guzman* to include ratings for a sleep disorder using Table 13-4 and for a psychiatric impairment using Table 13-8. What the chiropractor did not mention is that the date of injury in this case is in 2013, which makes this case subject to the restrictions of Labor Code § 4660.1(c)(1) and there is no evidence that the injury was from a violent act or a catastrophic injury. The only catastrophe is the lack of credibility of this MMI report.

Of major concern about this MMI report is that the chiropractor made the report look very authoritative, authentic, and comprehensive. It is clear that the doctor has a significant knowledge of the AMA *Guides*, but he dishonestly applies them in a case that may rate at the most a 13% WPI if the Applicant falls within a DRE III lumbar spinal impairment rating, which is most likely.

On the other hand, the trial judge is faced with a panel QME report that rates a DRE Category II 5% WPI, which is actually the equivalent of a severe back sprain with some positive findings on the imaging testing, probably the CT scan at L5-S1 for the 3-4 mm disc bulge. The PQME opined that the Applicant does not have a radiculopathy at the time of his MMI examination, which places the case within a DRE Category II. The PQME did not perform a range of motion analysis of the case, probably because he does not know how to. This is because of language he used in his report, that says the DRE method rates higher in this case than the Range of Motion method. Remember, that is a red flag, that the PQME does not know how to perform the 12 steps of the ROM method for the lumbar spine.

Therefore, is this case a 47% WPI or a 5% WPI? The best friend of a workers' compensation trial judge is *McDuffie v. Los Angeles Metropolitan Transportation Authority* [(2002) 67 Cal. Comp. Cases 138 (Appeals Board en banc decision)]. In many cases including this one, the trial judge has to develop the record. In this case, the trial judge vacated submission of the case for decision, ordered the parties to a further hearing, and requested that the parties agree to an agreed medical examiner in orthopedic surgery. Failing an agreement to use an AME, the judge will order a regular physician pursuant to Labor Code § 5701, which will result in an agreed medical examiner quality physician to sort this case out.

The other glaring problem with the treating physician's MMI report is that this Applicant is not a surgical candidate. How can a low back injury result in a 47% WPI rating when there was no surgery? That red flag can be seen by anyone who reviews this report.

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1. *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd., 187 Cal. App. 4th 808*
   Client/Matter: gustavo jimenez

Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd.

Court of Appeal of California, Sixth Appellate District

August 19, 2010, Filed

H034853

Reporter
187 Cal. App. 4th 808 *; 115 Cal. Rptr. 3d 112 **; 2010 Cal. App. LEXIS 1454 ***

MILPITAS UNIFIED SCHOOL DISTRICT, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and JOYCE GUZMAN, Respondents.

Subsequent History: Modified by *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd., 2010 Cal. App. LEXIS 1535 (Cal. App. 6th Dist., Sept. 1, 2010)*

Review denied by *Milpitas Unified School District v. Workers' Compensation Appeals Board, 2010 Cal. LEXIS 11677 (Cal., Nov. 10, 2010)*

Prior History: [***1] Workers Compensation Appeals Board, No. ADJ3341185, No. SJO0254688.

Core Terms

impairment, rating, disability, clinical, percent, permanent disability, measurements, rebuttal, percentages, workers' compensation, descriptions, upper extremity, rebut, instructions, permanent, accurately, subdivision, consistency, activities of daily living, percentage of permanent disability, substantial evidence, evaluator, authors, curiae, skill, spine, prima facie evidence, body part, incorporation, Industrial

Case Summary

Procedural Posture
Petitioner employer challenged a decision of respondent Workers' Compensation Appeals Board that an employee's impairment may be determined by reference to any applicable portion of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition (guides), and that this determination may be used to rebut the rating of permanent disability established by the 2005 Schedule for Rating Permanent Disabilities (PDRS).

Overview
The court of appeal agreed with the board that application of the guides to determine an employee's impairment rating under *Lab. Code, § 4660, subd. (b)(1)*, had to take into account the instructions on its use, which clearly prescribed the exercise of clinical judgment in the impairment evaluation, even beyond the descriptions, tables, and percentages provided for each of the listed conditions. The court also held that, as prima facie evidence of the percentage of permanent disability, the PDRS was not absolute, binding, and final. In order to support a case for rebuttal, a physician had to be permitted to explain why departure from the impairment percentages was necessary and how he or she arrived at a different rating. That explanation necessarily took into account the physician's skill, knowledge, and experience, and considerations unique to the injury at issue. A physician's explanation of the basis for deviating from the percentages provided in an applicable chapter of the guides was not a priori to be deemed insufficient merely because derived from extrinsic resources. A physician was free to acknowledge reliance on standard texts or recent research data.

Outcome
The court affirmed the board's decision.

LexisNexis® Headnotes

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN1[] **Benefit Determinations, Permanent Partial Disabilities**

The language of Lab. Code, § 4660, permits reliance on the entire American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, including the instructions on the use of clinical judgment, in deriving an impairment rating in a particular case.

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN2[] Benefit Determinations, Permanent Partial Disabilities

A schedule for assessing permanent disability has been required in workers' compensation cases since 1937, and it was always expressly intended to manifest prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. Lab. Code, § 4660, subd. (c). Under a 2004 amendment, the administrative director is required to develop and regularly amend the rating schedule based on specified data from empirical studies. The schedule shall promote consistency, uniformity, and objectivity. Lab. Code, § 4660, subd. (d). As so directed, the administrative director has published a 2005 Schedule for Rating Permanent Disabilities effective January 1, 2005, (PDRS) which incorporates in its entirety the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition. Cal. Code Regs., tit. 8, § 9805; PDRS p. 1-2.

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN3[] Benefit Determinations, Permanent Partial Disabilities

See Lab. Code, § 4660, subd. (b)(1).

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN4[] Benefit Determinations, Permanent Partial Disabilities

In determining the percentages of permanent disability in a workers' compensation case, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to an employee's diminished future earning capacity. Lab. Code, § 4660, subd.(a). The "nature of the physical injury" refers to impairment, which is expressed as a percentage reflecting the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), excluding work. In each case impairment ratings are combined and converted to a whole person impairment (WPI) rating, which reflects the impact of the injury on the overall ability to perform activities of daily living, excluding work. The WPI is then adjusted for diminished future earning capacity, the employee's occupation classification at the time of the injury, and age.

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN5[] Benefit Determinations, Permanent Partial Disabilities

Lab. Code, § 4660, subd. (b)(1), recognizes the variety and unpredictability of medical situations, when determining impairment in workers' compensation cases, by requiring incorporation of the descriptions, measurements, and corresponding percentages in the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, for each impairment, not their mechanical application without regard to how accurately and completely they reflect the actual impairment sustained by the patient. To "incorporate" is to unite with or introduce into something already existent, to take in or include as a part or parts, or to unite or combine so as to form one body. Section 4660, subd. (b)(1), thus requires the physician to include the descriptions, measurements, and percentages in the applicable chapter of the Guides as part of the basis for determining impairment. The court cannot expand the statutory mandate by changing the word "incorporate" to "apply exclusively." Nor can

the court read into the statute a conclusive presumption that the descriptions, measurements, and percentages set forth in each chapter are invariably accurate when applied to a particular case. By using the word "incorporation," the Legislature recognized that not every injury can be accurately described by the classifications designated for the particular body part involved.

Governments > Legislation > Interpretation

Workers' Compensation & SSDI > General Overview

HN6 **Legislation, Interpretation**

The workers' compensation statutes are construed liberally with the purpose of extending their benefits for the protection of persons injured in the course of their employment. *Lab. Code, § 3202*.

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN7 **Benefit Determinations, Permanent Partial Disabilities**

Application of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, in a workers' compensation case must take into account the instructions on its use, which clearly prescribe the exercise of clinical judgment in the impairment evaluation, even beyond the descriptions, tables, and percentages provided for each of the listed conditions. The descriptions, measurements, and percentages cannot be dissociated from the balance of the Guides, particularly Chapters 1 and 2, which contain the instructions on the appropriate use of the ensuing chapters to perform an accurate and reliable impairment evaluation. Thus, the AMA Guides is an integrated document and its statements in Chapters 1 and 2 regarding physicians using their clinical judgment, training, experience and skill cannot be divorced from the balance of the Guides.

Evidence > Inferences &

Presumptions > Presumptions > Rebuttal of Presumptions

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN8 **Presumptions, Rebuttal of Presumptions**

Lab. Code, § 4660, subd. (c), states that the Schedule for Rating Permanent Disabilities constitutes prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. A statute providing that a fact or group of facts is prima facie evidence of another fact establishes a rebuttable presumption. *Evid. Code, § 602*. Accordingly, as prima facie evidence the Schedule is not absolute, binding and final. It is therefore not to be considered all of the evidence on the degree or percentage of disability. Being prima facie it establishes only presumptive evidence which may be controverted and overcome. The 2004 amendment of *§ 4660* did not alter the prior versions that deemed the rating schedule to be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.

Governments > Legislation > Interpretation

HN9 **Legislation, Interpretation**

The Legislature is deemed to be aware of judicial decisions already in existence and to have enacted or amended a statute in light thereof. When a statute has been construed by judicial decision, and that construction is not altered by subsequent legislation, it must be presumed that the Legislature is aware of the judicial construction and approves of it.

Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities

Workers' Compensation & SSDI > Benefit Determinations > Permanent Total Disabilities

HN10 **Benefit Determinations, Permanent Partial Disabilities**

In order to support the case for rebuttal of the prima

facie evidence, provided by the Schedule for Rating Permanent Disabilities, as the degree or percentage of disability, a physician must be permitted to explain why departure from the impairment percentages is necessary and how he or she arrived at a different rating. That explanation necessarily takes into account the physician's skill, knowledge, and experience, as well as other considerations unique to the injury at issue. A physician's explanation of the basis for deviating from the percentages provided in an applicable chapter of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, should not a priori be deemed insufficient merely because his or her opinion is derived from, or at least supported by, extrinsic resources. The physician should be free to acknowledge his or her reliance on standard texts or recent research data as a basis for his or her medical conclusions, and the workers' compensation judge (WCJ) should be permitted to hear that evidence. If the explanation fails to convince the WCJ or Workers' Compensation Appeals Board that departure from strict application of the applicable tables and measurements in the Guides is warranted in the current situation, the physician's opinion will properly be rejected.

Headnotes/Summary

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

An employer challenged a decision of the Workers' Compensation Appeals Board that under Lab. Code, § 4660, an employee's impairment may be determined by reference to any applicable portion of the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th ed.) (Guides), and that this determination may be used to rebut the rating of permanent disability established by California's 2005 Schedule for Rating Permanent Disabilities (PDRS).

The Court of Appeal affirmed the board's decision, agreeing that application of the guides to determine an employee's impairment rating under Lab. Code, § 4660, subd. (b)(1), must take into account the instructions on its use, which clearly prescribe the exercise of clinical judgment in the impairment evaluation, even beyond the descriptions, tables, and percentages provided for each of the listed conditions. The court also held that, as prima facie evidence of the percentage of permanent disability, the PDRS is not absolute, binding, and final. In order to support the case for rebuttal, a physician must be permitted to explain why departure from the impairment percentages is necessary and how he or she arrived at a different rating. That explanation necessarily takes into account the physician's skill, knowledge, and experience, as well as other considerations unique to the injury at issue. A physician's explanation of the basis for deviating from the percentages provided in an applicable chapter of the Guides should not a priori be deemed insufficient merely because his or her opinion is derived from, or at least supported by, extrinsic resources. The physician should be free to acknowledge his or her reliance on standard texts or recent research data as a basis for medical conclusions, and the workers' compensation judge (WCJ) should be permitted to hear that evidence. If the explanation fails to convince the WCJ or Workers' Compensation Appeals Board that departure from strict application of the applicable tables and measurements in the Guides is warranted in **[*809]** the current situation, the physician's opinion will properly be rejected. (Opinion by Elia, J., with Premo, Acting P. J., and Duffy, J., concurring.)

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1)[↓] **(1)**

Workers' Compensation § 107—Permanent Disability Rating—Schedule—Prima Facie Evidence—Amendment—Empirical Studies.

A schedule for assessing permanent disability has been required in workers' compensation cases since 1937, and it was always expressly intended to manifest prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule (Lab. Code, § 4660, subd. (c)). Under a 2004 amendment, the administrative director is required to develop and regularly amend the rating schedule based on specified data from empirical studies. The schedule shall promote consistency, uniformity, and objectivity (Lab. Code, § 4660, subd. (d)). As so directed, the administrative director has published a 2005 Schedule for Rating Permanent Disabilities effective January 1, 2005 (PDRS), which incorporates in its entirety the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th ed.) (Cal. Code Regs., tit. 8, § 9805; PDRS, p. 1-2).

CA(2)[] (2)

Workers' Compensation § 107—Permanent Disability Rating—Factors—Nature of Physical Injury—Impairment.

In determining the percentages of permanent disability in a workers' compensation case, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to an employee's diminished future earning capacity (Lab. Code, § 4660, subd. (a)). The "nature of the physical injury" refers to impairment, which is expressed as a percentage reflecting the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living, excluding work. In each case impairment ratings are combined and converted to a whole person impairment (WPI) rating, which reflects the impact of the injury on the overall ability to perform activities of daily living, excluding work. The WPI is then adjusted for diminished future earning capacity, the employee's occupation classification at the time of the injury, and age.

CA(3)[] (3)

Workers' Compensation § 107—Permanent Disability Rating—Impairment—American Medical Association's Guides—Incorporation.

Lab. Code, § 4660, subd. (b)(1), recognizes the variety and unpredictability of medical situations, when determining impairment in workers' compensation cases, by requiring incorporation of the descriptions, measurements, **[*810]** and corresponding percentages in the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th ed.) (Guides), for each impairment, not their mechanical application without regard to how accurately and completely they reflect the actual impairment sustained by the patient. To "incorporate" is to unite with or introduce into something already existent, to take in or include as a part or parts, or to unite or combine so as to form one body. Section 4660, subd. (b)(1), thus requires the physician to include the descriptions, measurements, and percentages in the applicable chapter of the Guides as part of the basis for determining impairment. The court cannot expand the statutory mandate by changing the word "incorporate" to "apply exclusively." Nor can the court read into the statute a conclusive presumption that the descriptions, measurements, and percentages set forth in each chapter are invariably accurate when applied to a particular case. By using the word "incorporation," the Legislature recognized that not every injury can be accurately described by the classifications designated for the particular body part involved.

CA(4)[] (4)

Workers' Compensation § 81—Statutes—Liberal Construction.

The workers' compensation statutes are construed liberally with the purpose of extending their benefits for the protection of persons injured in the course of their employment (Lab. Code, § 3202).

CA(5)[] (5)

Workers' Compensation § 107—Permanent Disability Rating—Impairment—American Medical Association's Guides—Incorporation—Use of Clinical Judgment.

The court affirmed the holding of the Workers' Compensation Appeals Board that the language of Lab. Code, § 4660, permits reliance on the entire American Medical Association's Guides to the Evaluation of Permanent Impairment (5th ed.), including the chapters containing instructions on the use of clinical judgment, in deriving an impairment rating in a particular case.

[Hanna, Cal. Law of Employee Injuries and Workers' Compensation Law (2010) ch. 32, § 32.06; 2 Witkin, Summary of Cal. Law (10th ed. 2005) Workers' Compensation, § 288.]

CA(6)[] (6)

Workers' Compensation § 107—Permanent Disability Rating—Schedule—Prima Facie Evidence—Rebuttal.

Lab. Code, § 4660, subd. (c), states that the Schedule for Rating Permanent Disabilities constitutes prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. A statute providing that a fact or group of facts is prima facie evidence of another fact establishes a rebuttable presumption. (Evid. Code, § 602). Accordingly, as prima facie evidence the schedule is not absolute, binding and **[*811]** final. It is therefore not to be considered all of

the evidence on the degree or percentage of disability. Being prima facie it establishes only presumptive evidence which may be controverted and overcome. The 2004 amendment of § 4660 did not alter the prior versions that deemed the rating schedule to be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.

CA(7)[] (7)

Statutes § 45—Construction—Presumptions—Prior Judicial Interpretation.

The Legislature is deemed to be aware of judicial decisions already in existence and to have enacted or amended a statute in light thereof. When a statute has been construed by judicial decision, and that construction is not altered by subsequent legislation, it must be presumed that the Legislature is aware of the judicial construction and approves of it.

CA(8)[] (8)

Workers' Compensation § 107—Permanent Disability Rating—Schedule—Prima Facie Evidence—Rebuttal.

In order to support the case for rebuttal of the prima facie evidence, provided by the Schedule for Rating Permanent Disabilities, of the degree or percentage of disability, a physician must be permitted to explain why departure from the impairment percentages is necessary and how he or she arrived at a different rating. That explanation necessarily takes into account the physician's skill, knowledge, and experience, as well as other considerations unique to the injury at issue. A physician's explanation of the basis for deviating from the percentages provided in an applicable chapter of the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th ed.) should not a priori be deemed insufficient merely because his or her opinion is derived from, or at least supported by, extrinsic resources. The physician should be free to acknowledge his or her reliance on standard texts or recent research data as a basis for his or her medical conclusions, and the workers' compensation judge (WCJ) should be permitted to hear that evidence. If the explanation fails to convince the WCJ or Workers' Compensation Appeals Board that departure from strict application of the applicable tables and measurements in the Guides is warranted in the current situation, the physician's opinion will properly be rejected.

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[*812] David M. Skaggs for Pacific Compensation Insurance Company as Amicus Curiae on behalf of Petitioner.

Vanessa L. Holton, Steven A. McGinty and Jesse N. Rosen for John C. Duncan, Director of Industrial Relations, as Amicus Curiae on behalf of Petitioner.

Saul Allweiss and Michael A. Marks for California Workers' Compensation Institute and American Insurance Association as Amici Curiae on behalf of Petitioner.

Adam M. Cole, Richard G. Krenz and Christopher Citko for Steve Poizner, California Insurance Commissioner, as Amicus Curiae on behalf of Petitioner.

No appearance for Respondent Workers' Compensation Appeals Board.

J. Bruce Sutherland and Carla Spencer for Respondent Joyce Guzman.

Capurro, Rocha & Schmidt and Joseph V. Capurro for California Applicants' Attorneys Association as Amicus Curiae on behalf of Respondents.

David Bryan Leonard for California Society of Industrial Medicine & Surgery, Inc., as Amicus Curiae on behalf of Respondents.

Judges: Opinion by Elia, J., with Premo, Acting P. J., and Duffy, J., concurring.

Opinion by: Elia

Opinion

[114]** **ELIA, J.**—In this original proceeding the Milpitas Unified School **[***2]** District (District) challenges a decision of the Workers' Compensation Appeals Board (WCAB or Board) applying Labor Code section 4660 [1] to the disability evaluation of a District employee. The Board ruled that (1) an employee's

[1] All further statutory references are to the Labor Code except as otherwise specified.

impairment may be determined by reference to any applicable portion of the American Medical Association's Guides to the Evaluation of Permanent Impairment (5th ed.) (Guides), and (2) this determination may be used to rebut the rating of permanent disability established by the 2005 Schedule for Rating Permanent Disabilities (PDRS or Schedule). This court granted the District's petition for review. We conclude that ***HN1***[↑] the language of *section 4660* permits reliance on the entire Guides, including the instructions on the use of clinical judgment, in deriving an impairment rating in a particular case. We will therefore affirm the Board's decision.

Background

Joyce Guzman worked for the District as a temporary employee beginning in October 2001 and as a permanent employee, a secretary/clerk, from **[*813]** September 2002 to May 2005. The District was permissibly self-insured for workers' compensation **[***3]** liability; Keenan & Associates was its workers' compensation adjuster.

On November 5, 2003, Guzman's right foot became entangled in some computer wires under her desk, and as she rose and turned away, she fell. Over the following two and a half years, she sought treatment for pain in various locations on her body, as well as for psychiatric symptoms that led to prescriptions for antidepressants. Unsatisfied with the tests and recommendations of her Kaiser Permanente physicians, she turned to her attorney, who referred her to Dr. Fatteh. He diagnosed degenerative disc disease and prescribed physical therapy, a home muscle stimulator (for back spasms), chiropractic, and acupuncture. Gradually, Guzman progressed from modified work hours to an eight-hour workday "with restrictions." A flareup in May 2005 resulted in Dr. Fatteh's finding of a month-long total disability. On June 1, 2005, Dr. Fatteh noted Guzman's reduction in back and neck pain. While awaiting authorization for her to see a psychologist, she was to remain off work until August 1, 2005.

By September 2005 Dr. Fatteh reported that Guzman had experienced increased neck and low back pain, and he did not believe she would be able **[***4]** to return to her usual work. He recommended further psychotherapy and vocational rehabilitation, while predicting that Guzman would become "permanent and stationary" within three months. [2]

Guzman filed her first "Application for Adjudication of Claim" with the WCAB on February 9, 2004 (case No. SJO0244266), and a second application in August 2005 (case No. SJO0254688). [3] Steven D. Feinberg, M.D., the agreed medical evaluator (AME), examined Guzman on April 11, **[**115]** 2005, and issued supplemental reports on her progress thereafter. Dr. Feinberg diagnosed bilateral carpal tunnel syndrome, which had not been detected previously and which was the result of cumulative industrial trauma. In June 2005, Dr. Feinberg reviewed Dr. Fatteh's notes and concurred in the recommendation that Guzman remain off work temporarily.
[*814]

In his December 2, 2005 report, Dr. Feinberg noted Guzman's history of injuries prior to her employment with the District. [4] Guzman told him, however, that on November 5, 2003, she was in good health without any ongoing disability. Dr. Feinberg reported that Guzman continued to have cervical and lumbar discomfort as well as numbness and tingling in the hands "at times." Her symptoms were "worse with activity." Dr. Feinberg believed that Guzman was currently "permanent and stationary." Her spine condition precluded heavy lifting, and she had a "25% loss of her upper extremity preinjury capacity for pushing, pulling, grasping, gripping, keyboarding or fine manipulation." In an effort to apportion the disability, Dr. Feinberg attributed it to a combination of the 2003 injury, long-term work exposure, and other factors (e.g., genetics, habits, weight, and life exposure to nonindustrial conditions). Without speculating, however, he was unable to assign a percentage of the contribution from nonindustrial factors in this situation; consequently, he expressed the opinion that "the approximate **[***6]** percentage caused by the industrial injury/exposure is 100%."

On August 23, 2006, responding to a request for

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[2] "Permanent and stationary" is defined in the PDRS as "the point in time when the employee has reached maximal medical improvement (MMI), meaning his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment." (PDRS, p. 1-2; Guides, p. 2.)

[3] Case No. SJO0244266 is the number applicable to the **[***5]** date of injury, November 5, 2003. Case No. SJO0254688 applies to the subsequent period ending April 11, 2005.

[4] He briefly described a January 1998 foot injury; complaints of headaches in April 2000; a motor vehicle accident resulting in temporary neck, leg, arm and back pain; and complaints of headaches in October 2002.

clarification from the District's attorney, Dr. Feinberg clarified his "apportionment" findings. He explained that the November 2003 injury was responsible for the spine disability (which precluded heavy lifting) and the 25 percent loss of her preinjury capacity for pushing, pulling, grasping, gripping, and fine manipulation.

On July 13, 2007, Dr. Feinberg responded to a request by the District that he reanalyze the extent of Guzman's permanent disability in accordance with the Guides, using version 2.49 of the Dexter evaluation and impairment software. Dr. Feinberg reexamined Guzman and reported a total "whole person impairment" [5] of 14 percent, consisting of 3 percent on each upper extremity due to carpal tunnel syndrome, 5 percent impairment related to the lumbar spine, and 5 percent impairment related to the cervical spine injury.[6]

On March 21, 2008, Dr. Feinberg again examined Guzman. He related the patient's treatment history, including extended psychotherapy for depression, and noted that she continued to have cervical and lumbar "discomfort" as well as numbness and tingling in the hands, a loss of grip strength, and pain in her right leg. Dr. Feinberg concluded that she was "certainly" permanent **[*815]** and stationary at that time. He again estimated her upper extremity loss to be 25 percent of her preinjury capacity "for pushing, pulling, grasping, gripping, keyboarding or fine manipulation," and again he could not reliably apportion the loss between the injury and **[**116]** nonindustrial causes. Consequently, he assigned 100 percent causation to the "industrial injury/exposure."

Guzman's attorney asked for clarification of the 25 percent loss estimate. Dr. Feinberg explained that for the patient's low back and neck pain, "the 'old' PDRS should be used and that the new AMA-based PDRS was applicable to the bilateral upper **[***8]** extremities." He reiterated that Guzman was "precluded for her upper extremities from very forceful, prolonged repetitive and forceful repetitive work activities." Dr. Feinberg pointed out that "there is often a discrepancy between the disability and the impairment. The type of problem she has is legitimate but does not rate very much (if anything) under the AMA Guides. Based on her ADL [activities of daily living] losses, each upper extremity would have a 15% WPI [(]25% of 60%). This is not a method that is sanctioned by the AMA Guides."

Guzman's case was tried on July 10 and October 3, 2008. By stipulation, the 1997 PDRS was applied in SJO0244266, while the 2005 PDRS was applied in SJO0254688, the upper extremity trauma. She had already been compensated for her temporary disability; only the extent and apportionment of her permanent disability were at issue.

Karen Wong, the evaluator from the Disability Evaluation Unit (DEU), testified that the Guides did not permit a medical evaluator to compute WPI directly from ADL (activities of daily living) loss. [7] "She d[id]n't know why it's improper for the doctor to complete his own whole person impairment directly from ADL loss, but she [was] confident that the AMA **[***9]** Guides don't allow it." [8] If the 15 percent WPI figure Dr. Feinberg referred to were used for each upper extremity, each would yield a 22 percent permanent disability, which would combine to amount to a 39 percent overall permanent disability. However, Wong instead relied solely on the "carpal tunnel" portion of Dr. Feinberg's March 21, 2008 report, which allowed up to 5 percent for each upper extremity. Thus, relying on Dr. Feinberg's assignment of impairment **[*816]** based on the Guides, Wong rated Guzman's WPI as 3 percent for each upper extremity, for a total permanent disability of 12 percent.

In an October 22, 2008 amended ruling, the workers' compensation judge (WCJ) found that Guzman had sustained permanent partial disability of 41 percent in SJO0244266 and 12 percent in SJO0254688. The

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[5] "Whole person impairment," **[***7]** often abbreviated as "WPI," is defined in the Guides as "[p]ercentages that estimate the impact on the individual's overall ability to perform activities of daily living, excluding work." (Guides, p. 603.)

[6] Dr. Feinberg did not explain precisely how he arrived at the total of 14 percent.

[7] The DEU had received instructions to rate the injury to the upper extremities using the March 21, 2008 report, and to consider Dr. Feinberg's point that Guzman's ADL losses should produce a 15 percent WPI, but that the Guides do not sanction that method of determining impairment. If the DEU evaluator found the doctor's alternative method as "ratable," she was to calculate impairment by "whichever method produces the highest rating." Wong, however, was convinced that the Guides did not allow impairment to be determined directly from ADL loss, so she did not use the 15 percent figure in her **[***10]** rating.

[8] Wong said she had relied on Dr. Feinberg's statement that his impairment calculation based on ADL loss was not sanctioned by the Guides. She did not express an opinion about whether this statement was right or wrong, as it was not within her expertise.

WCJ's decision was based on Dr. Feinberg's opinions as well as psychiatric reports by Michael D. Goldfield, M.D. The WCJ found no sufficient basis for attributing any permanent disability to Guzman's psychiatric injury, which was inseparable from the 2005 physical injury.

Noting the discrepancy between Dr. Feinberg's assessment of Guzman's injury outside the rating system provided in the Guides, the WCJ stated, "Applicant has **[**117]** advanced the theory that, since Dr. Feinberg has opined that the Applicant's impairment precludes a higher level of ADL's than described in the AMA Guides, Dr. Feinberg's report is a sufficient rebuttal of the Schedule and should be rated outside AMA [*sic*]. While the exact quantum of evidence required to rebut **[***11]** the PDRS has yet to be established by case law, I feel certain that a single paragraph in an AME report does not suffice. In particular, Dr. Feinberg provides no data or clinical observations in support of his opinion; his opinion seems to be, rather, that the [G]uides generally underrate this impairment. He may be correct; he is certainly a highly respected and qualified physician; but without a significant amount of objective data I am unwilling to accept his opinion, standing alone, against that of the Legislature."

Guzman petitioned for reconsideration of case No. SJO0254688 with the WCAB, contending that the evidence did not support the factual findings, the findings did not support the award, and the WCJ had exceeded his authority. [9] Relying on Dr. Feinberg's report of a 15 percent WPI per upper extremity (from 25 percent ADL loss), Guzman contended that her permanent disability "should be an adjusted 39 %, based upon the AME's clinical judgment and reporting, and the DEU rater's 10/03/2008 testimony." Guzman maintained that this method of calculation was consistent with the Guides. She was not, she insisted, seeking to rebut the current permanent disability schedule, but instead "to **[***12]** appropriately and accurately apply it." The Guides themselves, she argued, required the evaluating physician to exercise clinical judgment, and to take note of any functional loss of ADL's in deriving an impairment rating. Thus, it was a "mistake" to believe that the AMA (American Medical Association) did not approve of Dr. Feinberg's method of assessing impairment based on functional loss of ADL's. The WCJ should have recognized **[*817]** that the application of clinical judgment to the AME's assessment of impairment and disability, including impairment of ADL's, was consistent with the current PDRS.

Keenan & Associates responded that substantial evidence supported the WCJ's decision. If Guzman disagreed, she should have retained an expert to rebut Wong's rating. The WCJ agreed, noting that no direct evidence contradicted the expert opinion that the Guides may not be bypassed in favor of a physician's independent evaluation method. "On this record, it would be an abuse of discretion to rate in a manner other than that supported by the evidence."

The WCAB, however, granted the petition for reconsideration and combined the **[***13]** case with an ongoing dispute in *Almaraz v. Environmental Recovery Services* (*Almaraz*). [10] In its ensuing decision on February 3, 2009, the WCAB ruled that "(1) the AMA Guides portion of the 2005 Schedule is rebuttable; (2) the AMA Guides portion of the 2005 Schedule is rebutted by showing that an impairment rating based on the AMA Guides would result in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent **[**118]** disability; and (3) when an impairment rating based on the AMA Guides has been rebutted, the WCAB may make an impairment determination that considers medical opinions that are not based or are only partially based on the AMA Guides." The WCAB accordingly remanded the matter to the WCJ to determine whether the standards it had outlined for rebutting the Guides had been met.

The State Compensation Insurance Fund (SCIF), the insurer in the *Almaraz* case, petitioned for reconsideration. The WCAB granted the petition and, in the interests of consistency, granted reconsideration on its own motion in Guzman's case.

On September 3, 2009, the WCAB issued its final decision in a four-to-three opinion partially reversing its February 3 decision. The majority reaffirmed its prior ruling that an impairment rating under the Guides was rebuttable, but it rejected the previous language allowing such rebuttal if those ratings resulted in an

[9] Only case No. SJO0254688 was the subject of the petition for reconsideration or any of the ensuing proceedings.

[10] Mario Almaraz was a truckdriver who hurt his back while pulling a tarp onto the top of the trailer portion of his truck. Challenging the WCJ's finding of a 14 percent permanent disability rating, he contended that the Guides should not be "blindly followed" where it did not fairly and accurately describe and measure the employee's **[***14]** impairment; in such cases, he argued, other measures of disability should be used.

inequitable, disproportionate, and inaccurate rating of permanent disability. Under the Board's new holding, an employee or defendant could rebut the percentage of permanent disability under the 2005 Schedule "by successfully challenging any one of the individual **[*818]** component elements of the formula that resulted in the employee's scheduled rating." One of those components, the person's WPI, could be challenged through the presentation of evidence that a different chapter, table, or method contained in the Guides more accurately describes the impairment. **[***15]** Whether in the initial determination of WPI or in rebuttal, a physician could "utilize any chapter, table, or method in the AMA Guides that most accurately reflects the injured employee's impairment," but was not permitted to "go outside the four corners of the AMA Guides." The three-person minority of the Board disagreed with that restriction, preferring the first standard. This court granted the District's petition for writ review.

Discussion

1. *Section 4660*

CA(1)[↑] **(1)** The workers' compensation system in California underwent comprehensive reform in 2004 with the passage of Senate Bill No. 899 (2003–2004 Reg. Sess.). This was "an urgency measure designed to alleviate a perceived crisis in skyrocketing workers' compensation costs." (*Brodie v. Workers' Comp. Appeals Bd. (2007) 40 Cal.4th 1313, 1329 [57 Cal. Rptr. 3d 644, 156 P.3d 1100]*; but see *Benson v. Workers' Comp. Appeals Bd. (2009) 170 Cal.App.4th 1535, 1557 [89 Cal. Rptr. 3d 166]* [both workers and employers were intended to benefit from Sen. Bill No. 899 (2003–2004 Reg. Sess.)].) The revised provisions substantially affected the assessment of an injured worker's permanent disability. *HN2*[↑] A schedule for assessing permanent disability had been required since 1937, and it was always expressly intended to manifest "prima **[***16]** facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." (*§ 4660, subd. (c)*.) As the WCAB observed, however, no guidance was provided for the formulation of the schedule until the 2004 amendment. In accordance with the revision, the administrative director is now required to develop and regularly amend the rating schedule based on specified data from empirical studies. The schedule "shall promote consistency, uniformity, and objectivity." (*§ 4660, subd. (d)*.) As so directed, the administrative director published a new PDRS effective January 1, 2005, which incorporated the fifth edition of the Guides in its entirety. (*Cal. Code Regs., tit. 8, § 9805*; PDRS, p. 1-2.)

[119]** 2. *Impairment and Disability*

The statutory revision most significant for the resolution of Guzman's case is the new condition that the determination of *HN3*[↑] "the 'nature of the physical injury or disfigurement' shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition)." (*§ 4660, subd. (b)(1)*.)
[*819]

First **[***17]** published in 1971 to provide "a standardized, objective approach to evaluating medical impairments" (Guides, § 1.1, p. 1), the AMA Guides sets forth measurement criteria that certified rating physicians and chiropractors can use to ascertain and rate the medical impairment suffered by injured workers. (*Id.*, § 1.2, p. 4.) "Impairment" is defined in the Guides as "a loss, loss of use, or derangement of any body part, organ system or organ function." (Guides, § 1.2, p. 2.) The impairment ratings provided in the Guides "were designed to reflect functional limitations and not disability." (Guides, § 1.2, p. 4.) They "reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), *excluding* work." [11] (Guides, § 1.2, p. 4.)

A permanent disability, on the other hand, " ' "causes impairment of earning capacity, **[***18]** impairment of the normal use of a member, or a competitive handicap in the open labor market." ' " (*Brodie v. Workers' Comp. Appeals Bd., supra, 40 Cal.4th at p. 1320.*) "A disability is considered permanent when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment." (*Cal. Code Regs., tit. 8, § 10152*.) Permanent disability is expressed as a percentage: Anything less than 100 percent (total disability) entitles

[11] ADL consists of everyday activities such as self-care, personal hygiene, communication, physical activity, sensory function, nonspecialized hand activity (i.e., grasping, lifting, tactile discrimination), travel, sexual function, and sleep. (Guides, § 1.2, p. 4.)

the injured worker to a prescribed number of weeks of indemnity payments in accordance with that percentage. (Lab. Code, § 4658.) "Thus, permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future earning capacity." (*Brodie v. Workers' Comp. Appeals Bd., supra, 40 Cal.4th at p. 1320.*)

CA(2)[↑] (2) "HN4[↑] In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to an employee's diminished future earning capacity." [12] (§ 4660, subd. (a).) [***19] The "nature of the physical injury" refers to impairment, which is expressed as a percentage reflecting the "severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), [*820] *excluding* work." [13] (Guides, § 1.2, [**120] p. 4, original italics.) In each case impairment ratings are combined and converted to a WPI rating, [14] which reflects the impact of the injury on the "overall ability to perform activities of daily living, excluding work." [15] (Guides, p. 603.) The WPI is then adjusted for diminished future earning capacity (DFEC), the employee's occupation classification at the time of the injury, and age. [16] Of these four components, it is the "nature of the injury," expressed in terms of impairment, that is the source of the controversy in this case.

3. *Standard and Scope of Review*

The primary issue in this dispute is whether section 4660, following the 2004 revisions, permits deviation from a strict application of the descriptions, measurements, and percentages contained in the Guides for purposes of determining the impairment resulting from an employee's workplace injury. This question calls for construction and application of section 4660, and more specifically, subdivisions (b)(1) and (c) of that statute. "Issues of statutory interpretation are questions of law subject to our independent or de novo review. [Citations.] Nonetheless, unless clearly erroneous the WCAB's interpretation of the workers' compensation laws is entitled to great weight. [Citations.]" (*Genlyte Group, LLC v. Workers' Comp. Appeals Bd. (2008) 158 Cal.App.4th 705, 714 [69 Cal. Rptr. 3d 903]*; see also *Vera v. Workers' Comp. Appeals Bd. (2007) 154 Cal.App.4th 996, 1003 [65 Cal. Rptr. 3d 151]*; [***22] accord, *Tanimura & Antle v. Workers' Comp. Appeals Bd. (2007) 157 Cal.App.4th 1489, 1494 [69 Cal. Rptr. 3d 127].*) At the same time, the workers' compensation statutes must be "liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of [*821] their employment." (§ 3202.) This rule is binding on both the Board and this court and is applicable to all aspects of workers' compensation law. (*Lundberg v. Workmen's Comp. App. Bd. (1968) 69 Cal.2d 436, 439 [71 Cal. Rptr. 684, 445 P.2d 300]*; *Department of Rehabilitation v. Workers' Comp. Appeals Bd. (2003) 30 Cal.4th 1281, 1290 [135 Cal. Rptr. 2d 665, 70 P.3d 1076].*)

In construing section 4660, the reviewing court must

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[12] The prior version of section 4660, subdivision (a), referred to the "diminished ability of such injured employee to compete in an open labor market" rather than the employee's diminished future earning capacity. (See Stats. 1993, ch. 121, § 53, p. 1301.)

[13] The authors explain the exclusion by pointing out that the "medical judgment [***20] used to determine the original impairment percentages could not account for the diversity or complexity of work but could account for daily activities common to most people. Work is not included in the clinical judgment for impairment percentages for several reasons: (1) work involves many simple and complex activities; (2) work is highly individualized, making generalizations inaccurate; (3) impairment percentages are unchanged for stable conditions, but work and occupations change; and (4) impairments interact with such other factors as the worker's age, education, and prior work experience to determine the extent of work disability. ... As a result, impairment ratings are not intended for use as direct determinants of work disability." (Guides, § 1.2, p. 5.)

[14] A WPI rating of 0 percent means that the impairment "has no significant organ or body system functional consequences and does not limit the performance of the common activities of daily living." (Guides, § 1.2, p. 5.) A 90–100 percent WPI, on the other hand, "indicates a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death." (Guides, § 1.2, p. 5.)

[15] Impairment [***21] of an upper extremity, for example, is converted to a WPI by multiplying the impairment rating by 0.6.

[16] DFEC is determined by applying a "formula based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees." (§ 4660, subd. (b)(2).)

"ascertain the intent of the Legislature so as to effectuate the purpose **[**121]** of the workers' compensation law. In determining such intent, we turn to the words in the statute and give effect to the statute according to the usual, ordinary import of the language used in framing it." (*Klee v. Workers' Comp. Appeals Bd. (1989) 211 Cal.App.3d 1519, 1523 [260 Cal. Rptr. 217]*.) "When the language is clear and there is no uncertainty as to the legislative intent, we look no further and simply enforce the statute according to its terms. [Citations.] [¶] ... ' "If possible, significance should **[***23]** be given to every word, phrase, sentence and part of an act in pursuance of the legislative purpose." [Citation.] ... "When used in a statute [words] must be construed in context, keeping in mind the nature and obvious purpose of the statute where they appear." [Citations.] Moreover, the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole. [Citations.]' " (*DuBois v. Workers' Comp. Appeals Bd. (1993) 5 Cal.4th 382, 387–388 [20 Cal. Rptr. 2d 523, 853 P.2d 978]*.)

4. *Impairment Ratings Under Section 4660, Subdivision (b)(1)*

The District's position on appeal is a narrow one: Whereas the PDRS is rebuttable, the criteria set forth in the Guides are *not* rebuttable for purposes of making a determination of WPI. Relying primarily on *section 4660, subdivision (b)(1)*, the District points out that determination of an employee's impairment must *incorporate* the descriptions and measurements set forth in the Guides. This provision, in the District's view, mandates the application of the Guides "as written" and "as intended" and prohibits physicians from "rewriting the *Guides* by applying 'any chapter, table or method' he/she **[***24]** deems more appropriate." Thus, the District argues, "the *Guides*, properly applied, are the final word on impairment. There is no other way to interpret the plain language of *section 4660*."

Several parties have filed amicus curiae briefs, most of them in support of the District. [17] Those parties join the District in arguing that the Guides must **[*822]** be used "as written" in order for the Schedule to promote consistency, uniformity, and objectivity. The Board's decision, they argue, defeats that objective by allowing impairment ratings to be based on chapters that do not apply to the employee's injury. The Insurance Commissioner adds that since the passage of Senate Bill No. 899 (2003–2004 Reg. Sess.) permanent disability costs have decreased and become "determinable, predictable, and quantifiable," an effect he believes will be lost with the current decision.

CA(3)[↑] **(3)** Applying the settled rules of statutory construction, we agree with the District that the Guides must be applied "as intended" and "as written," but we take a broader view of both its text and the statutory mandate. *HN5*[↑] *Section 4660, subdivision (b)(1)*, recognizes the variety and unpredictability of medical situations by requiring *incorporation* of the descriptions, measurements, and corresponding percentages in the Guides for each impairment, not their mechanical application without regard to how accurately and completely they reflect the actual impairment sustained **[**122]** by the patient. To "incorporate" is to "unite with or introduce into something already existent (Webster's 3d New Internat. Dict. (1993) p. 1145)," to "take in or include as a part or parts" (Random House Dict. of the English Language (2d ed. 1987) p. 968), or to "unite or combine so as to form one body." (American Heritage Dict. (3d ed. 1994) p. 588.) *Section 4660, subdivision (b)(1)*, thus requires the physician to include the descriptions, measurements, and percentages in the applicable chapter of the Guides **[***26]** as part of the basis for determining impairment.

CA(4)[↑] **(4)** We cannot expand the statutory mandate by changing the word "incorporate" to "apply exclusively." Nor can we read into the statute a conclusive presumption that the descriptions, measurements, and percentages set forth in each chapter are invariably accurate when applied to a particular case. By using the word "incorporation," the Legislature recognized that not every injury can be accurately described by the classifications designated for the particular body part involved. Had the Legislature wished to require every complex situation to be forced into preset measurement criteria, it would have used different terminology to compel strict adherence to those criteria for every condition. A narrower interpretation would be inconsistent with the clear provision that the Schedule—which itself incorporates the Guides (PDRS,

[17] Amici curiae for the District are the California Chamber of Commerce; Employers Direct Insurance Company (Employers Direct), later renamed Pacific Compensation Insurance Company; John C. Duncan, Director of Industrial Relations; California Workers' Compensation Institute and American Insurance Association; and Steve Poizner, California Insurance Commissioner. In support of Guzman **[***25]** and the WCAB are the California Applicants' Attorneys Association and the California Society of Industrial Medicine and Surgery.

p. 1-2)—is rebuttable (§ 4660, subd. (c)), and it would not comport with the legislative directive to construe HN6[↑] the workers' compensation statutes liberally "with the purpose of extending their benefits for the protection of persons injured in the course of their employment." (§ 3202.)

We disagree with the District and [***27] its supporting amici curiae that this construction of section 4660, subdivision (b)(1), would defeat the legislative [*823] objective of consistency, uniformity, and objectivity. (§ 4660, subd. (d).) Just as it charges the Board with incorrectly attaching "prima facie evidence" to the measures of impairment in the Guides rather than the disability ratings in the Schedule, the District itself has attached the Legislature's goal of promoting consistency, uniformity, and objectivity of the *Schedule* to the impairment evaluation. Subdivision (d) of the statute is specifically addressed to the development, adoption, and amendment of the Schedule itself, not the physician's evaluation of impairment. Nevertheless, we have no reason to question the implicit assumption that while directing those features to the Schedule itself, the Legislature sought consistency, uniformity, and objectivity in the overall process of determining disability across individuals.

The District agrees with the statement by the authors of the Guides that its application "as intended" facilitates "an appropriate and reproducible assessment to be made of clinical impairment." (Guides, p. 11.) However, the District omits the rest of [***28] that paragraph, which makes a rather different point, an important one: "The physician's *judgment*, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the *Guides* criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment. Clinical judgment, combining both the 'art' and 'science' of medicine, constitutes the essence of medical practice." (Guides, § 1.5, p. 11.) The Guides itself recognizes that it cannot anticipate and describe every impairment that may be experienced by injured employees. The authors repeatedly caution that notwithstanding its "framework for evaluating new or complex conditions," the "range, evolution, and discovery of new medical conditions" preclude ratings for every possible impairment. (Guides, § 1.5, p. 11.) The Guides ratings [**123] do provide a standardized basis for reporting the degree of impairment, but those are "consensus-derived estimates," and some of the given percentages are supported by only limited research data. (Guides, pp. 4, 5.) The Guides also cannot rate syndromes that are "poorly understood and are manifested only by subjective symptoms." (*Ibid.*)

To accommodate [***29] those complex or extraordinary cases, the Guides calls for the physician's exercise of clinical judgment to assess the impairment most accurately. Indeed, throughout the Guides the authors emphasize the necessity of "considerable medical expertise and judgment," as well as an understanding of the physical demands placed on the particular patient. (Guides, p. 18.) "The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing." (Guides, p. 19.) The PDRS itself [*824] instructs physicians that if a particular impairment is not addressed by the AMA Guides, they "should use clinical judgment, comparing measurable impairment resulting from the unlisted objective medical condition to measurable impairment resulting from similar objective medical conditions with similar impairment of [***30] function in performing activities of daily living." [18] (PDRS, p. 1-4.)

CA(5)[↑] (5) Accordingly, while we agree with the District that the Guides should be applied "as intended" by its authors, such HN7[↑] application must take into account the instructions on its use, which clearly prescribe the exercise of clinical judgment in the impairment evaluation, even beyond the descriptions, tables, and percentages provided for each of the listed conditions. The Board aptly observed that the descriptions, measurements, and percentages cannot be dissociated from the balance of the Guides, particularly chapters 1 and 2, which contain the instructions on the appropriate use of the ensuing chapters to perform an accurate and reliable impairment evaluation. "Thus, the AMA Guides is an integrated document and its statements in Chapters 1 and 2 regarding physicians using their clinical judgment, training, experience and skill cannot be divorced [***31] from the balance of the Guides."

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[18] Similarly, when multiple impairments result from a single injury, the physician must exercise judgment to avoid duplication of effects on function of the injured body part, to the extent that the Guides do not provide direction regarding combining the impairments. (PDRS, p. 1-5.)

The District and supporting amici curiae nevertheless maintain that the Board's decision will result in burdensome litigation, inconsistent ratings, employer-employee conflicts, and "doctor shopping." They contend that the "very foundation of the new statute" will be subverted because it will allow a physician "unrestrained license" to manipulate the Guides through an "ad hoc" approach based on subjective considerations, "without any need to evaluate the doctor's opinion against the objective evidence." According to the Chamber of Commerce, the Guides will be rendered "*irrelevant* whenever a[n] evaluating physician and/or the WCJ disagrees with the result." Like the District, which warns that a physician will now be able to "make up impairment values where none exist," Employers Direct is concerned that the **[**124]** physician's opinion will prevail simply by its "mantra of accuracy." The District invokes the scenario of a spine injury accompanied by difficulty lifting and sleep disturbance, which the physician evaluates by using chapter 6.6 on hernias or chapter 13.3c on sleep disorders or both, thus arriving at a radically different impairment value than that prescribed **[***32]** in chapter 15 on the spine. The Chamber of Commerce illustrates its position with the same example: Instead of requiring evaluation of a lumbar spine injury using chapter 15, the Board's decision "would actually allow a physician to base impairment in [*sic*] Chapter Six (Digestive System), ordinarily reserved for **[*825]** impairment due to a hernia—*even in the absence of a hernia*—if the physician decides that it really is 'more accurate.' Or, even though the Guides specifically disfavor impairment ratings based on 'grip loss' or 'gait derangement' due to the inherently subjective nature of the testing, the decision below would permit a finding of impairment based on these disapproved methods ... so long as the physician subjectively believes that they really provide a more accurate representation of the impairment."

The abuses the District and its amici curiae envision are not inevitable outcomes of the WCAB's decision, however. Any patient can shop for the most favorable physician report regardless of how strictly the Guides are applied, as examinations, testing, and conclusions can vary among physicians in any given context. As to the second point urged by the District and its amici curiae, the Board **[***33]** emphasized that its decision does *not* allow a physician to conduct a fishing expedition through the Guides "simply to achieve a desired result"; the physician's medical opinion "must constitute substantial evidence" of WPI and "therefore ... must set forth the facts and reasoning [that] justify it." "In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. [Citation.] Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. [Citation.] Further, a medical report is not substantial evidence unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions. [Citation.]" (*E.L. Yeager Construction v. Workers' Comp. Appeals Bd. (2006) 145 Cal.App.4th 922, 928 [52 Cal. Rptr. 3d 133].*)

Accordingly, a physician's medical opinion that departs unreasonably from a strict application of the Guides can be challenged, and it would not be acceptable as substantial evidence or fulfill the overall goal of compensating an injured employee commensurate with the disability he or **[***34]** she incurred through the injury. If Guzman's carpal tunnel syndrome, for example, is adequately addressed by the pertinent sections of chapter 16, an impairment rating that deviates from those provisions will properly be rejected by the WCJ. As the Board's decision does not disregard, retreat from, or compromise the requirement of substantial evidence, we cannot conclude that it erred to the extent that it allows physicians to use their clinical judgment in applying the Guides. The District's assertion that the WCAB's decision encourages a physician to misapply the Guides freely by using " 'any chapter, table or method' he/she deems more appropriate" is not well taken.

Unlike the District, which acknowledges the importance of the Guides instructions, amicus curiae Employers Direct insists that section 4660 permits incorporation of *only* the " 'descriptions and measurements of physical **[*826]** impairments and the corresponding percentages of impairments published in **[**125]** the [Guides]' into the definition of 'the nature of the physical injury or disfigurement.' " According to this theory, the Legislature did not intend to incorporate any other portions of the Guides, including the first two chapters instructing **[***35]** physicians on the proper use of the Guides to evaluate impairment. [19] We reject this argument. Those first two chapters make it clear that an impairment rating based solely on the descriptions, measurements, and percentages in the succeeding

[19] The California Workers' Compensation Institute and the American Insurance Association take the opposite approach, arguing instead that the decision is wrong because it "does not require the physician to follow the explicit directions and instructions established within the AMA Guides."

chapters without the use of physicians' clinical judgment, training, experience, and skill would contravene the assumptions and intent of the authors. The failure to follow all of the instructions in the first two chapters could result in useless evidence, inadequate diagnostic reasoning, and inaccurate and inconsistent ratings.

The Board thus correctly rejected the argument that only the descriptions and measurements of impairments with their corresponding percentages may be incorporated into the WPI assessment. The statute, noted the Board, did not *prohibit* incorporation of the portions outside the descriptions, measurements, and percentages in a complex case not **[***36]** addressed by the chapter devoted to the affected body part or system. In the Board's view, the administrative director complied with the statutory mandate by adopting and incorporating the *entire* Guides without limitation. As a result, the Board concluded, "the entire AMA Guides is part of the Schedule." Given the comprehensiveness and precision attendant in the chapters pertaining to each system, in most cases a WCJ will credit ratings based strictly on the chapter devoted to the body part, region, or system affected.

5. *Rebuttal of the PDRS*

CA(6)[↑] **(6)** The WCAB rested its decision in part on HN8[↑] section 4660, subdivision (c), which states that the PDRS constitutes "prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." "A statute providing that a fact or group of facts is prima facie evidence of another fact establishes a rebuttable presumption." (Evid. Code, § 602.) Accordingly, as "prima facie evidence" the Schedule is not "absolute, binding and final. [Citations.] It is therefore not to be considered all of the evidence on the degree or percentage of disability. Being prima facie it establishes only presumptive evidence [which] may **[***37]** be controverted and overcome." (Universal City Studios, Inc. v. Worker's Comp. Appeals Bd. (1979) 99 Cal.App.3d 647, 662–663 [160 Cal. Rptr. 597].)
[*827]

CA(7)[↑] **(7)** As the District acknowledges, the 2004 amendment of section 4660 did not alter the prior versions that deemed the rating schedule to be "prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule."[20] (See Frankfort General Ins. Co. v. Pillsbury (1916) 173 Cal. 56, 58–60 [159 P. 150].) The Board noted preamendment decisions confirming the rebuttability of the Schedule. (See, e.g., Glass v. Workers' Comp. Appeals Bd. (1980) 105 Cal.App.3d 297, 307 [164 Cal. Rptr. 312] [where schedule does not accurately reflect true disability, "it may be **[**126]** controverted and overcome"]; cf. Universal City Studios, Inc. v. Worker's Comp. Appeals Bd., supra, 99 Cal.App.3d at p. 663 [presumption "totally overcome" by evidence that employee medically able to return to work but chose not to do so].) HN9[↑] "The Legislature is deemed to be aware of judicial decisions already in existence and to have enacted or amended a statute in light thereof. [Citation.] When a statute has been construed by judicial decision, and that construction is not altered by subsequent **[***38]** legislation, it must be presumed that the Legislature is aware of the judicial construction and approves of it." (Stavropoulos v. Superior Court (2006) 141 Cal.App.4th 190, 196 [45 Cal. Rptr. 3d 705]; see White v. Ultramar, Inc. (1999) 21 Cal.4th 563, 572 [88 Cal. Rptr. 2d 19, 981 P.2d 944].)

The WCAB's decision permits rebuttal of the PDRS by challenging "any one of the component elements of the formula that resulted in the employee's scheduled rating—such as the injured employee's WPI under the AMA Guides." To make an impairment determination in rebuttal of the Schedule, the physician is permitted by the Board to use the "four corners of the Guides."

The Board stated that by having the latitude to use the "four corners" of the Guides, the physician "is not inescapably locked into any specific paradigm for evaluating WPI under the Guides." The statute, the Board reasoned, "does not mandate that the impairment for any particular condition must be assessed in any particular way under the Guides [or] relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning **[***39]** a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment. Instead, the AMA Guides expressly contemplates that a physician will use his or her judgment, experience, training, and skill in assessing WPI."

Nevertheless, the District, the Director of Industrial

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[20] The Board has previously noted the retention of this language. (See Costa v. Hardy Diagnostic (2006) 71 Cal.Comp.Cases 1797.)

Relations, and the California Chamber of Commerce interpret subdivision (c) of section 4660 to **[*828]** mean that only the *final* percentage rating of disability can be rebutted, not any one of its four components. Likewise, Employers Direct would limit rebuttal to "a substantive level beyond the elements defined by the Legislature." None explains, however, how the "*end product*" or higher "substantive level" is rebuttable without challenging any of its elements.

The Chamber of Commerce reiterates the view that if the decision stands, the Guides "could be rebutted whenever they yield a result that someone concludes is 'inaccurate.' " Simply presenting a view contrary to an established rating in the Guides, however, would not be sufficient to rebut the PDRS rating. As discussed earlier, an impairment rating that is inadequately supported by evidence and reasoning—and unquestionably, a rebuttal position **[***40]** arrived at by hunting through the Guides for a more favorable rating—will result in an opinion the WCJ will necessarily reject as insufficient evidence. The Board itself emphasized that substantial evidence is necessary to establish a permanent disability, and any opinion proffered without "facts and reasoning [that] justify it" will not be sufficient. Any WCJ would err by allowing the scheduled rating to be rebutted based on an obviously inapplicable section of the Guides. [21]

[127]** As discussed earlier, the PDRS has expressly incorporated the entire Guides, which necessarily includes its instructions on the proper application of the chapters pertaining to each specific body area or system—notably, the authors' recommendation that physicians use clinical judgment when a condition is not covered by the impairment ratings in the Guides. The Board's decision is consistent with those instructions by acknowledging the necessity of the physician's exercise of "judgment, experience, training, and skill in assessing WPI."

CA(8)[↑] **(8)** At the same time, however, the WCAB majority **[***41]** did not explain how far the physician may go in relying on the "four corners" when the descriptions, tables, and percentages pertaining to an injury do not accurately describe the injured employee's impairment. [22] If the physician expresses the opinion that the chapter applicable to a particular kind of injury does not describe the employee's injury, but all other chapters address completely different biological systems or body parts, it would likely be difficult to demonstrate that that alternative chapter supplies substantial, relevant evidence of an alternative WPI rating. HN10[↑] In order to support the case for rebuttal, **[*829]** the physician must be permitted to explain why departure from the impairment percentages is necessary and how he or she arrived at a different rating. That explanation necessarily takes into account the physician's skill, knowledge, and experience, as well as other considerations unique to the injury at issue. In our view, a physician's explanation of the basis for deviating from the percentages provided in the applicable Guides chapter should not a priori be deemed insufficient merely because his or her opinion is derived from, or at least supported by, extrinsic resources. **[***42]** The physician should be free to acknowledge his or her reliance on standard texts or recent research data as a basis for his or her medical conclusions, and the WCJ should be permitted to hear that evidence. If the explanation fails to convince the WCJ or WCAB that departure from strict application of the applicable tables and measurements in the Guides is warranted in the current situation, the physician's opinion will properly be rejected. Without a complete presentation of the supporting evidence on which the physician has based his or her clinical judgment, the trier of fact may not be able to determine whether a party has successfully rebutted the scheduled rating or, instead, has manipulated the Guides to achieve a more favorable impairment assessment.

6. *Illegal Regulation*

The District finally asserts that the WCAB "usurped the [administrative **[***43]** director's] authority to create a Schedule as set forth in section 4660 by asserting [that] the *Guides* need not be applied as written, to derive a [permanent disability] rating." According to the District, the Board "has substituted its priorities (deriving the 'most accurate' impairment) for the Legislature's primary concerns: (a) consistency, uniformity, and objectivity; and (b) providing relief from the workers' compensation crisis." By "attacking and rewriting the *Guides*," and thereby "adopting an entirely new and different methodology of calculating [permanent disability], the

[21] Indeed, the WCJ in this case rejected Dr. Feinberg's rebuttal for lack of "data or clinical observations in support of his opinion."

[22] The dissent would have returned to the Board's first decision and allowed rebuttal by considering factors *outside* the Guides whenever its application would be "inequitable, disproportionate, and not a fair and accurate measure of the [injured] employee's permanent disability." Guzman has not suggested that we revisit this earlier standard.

WCAB has effectively created new regulations," in violation of the Administrative Procedure Act. (Gov. Code, § 11340 et seq.)

We cannot reach the conclusion urged by the District because the premise of its **[**128]** argument is faulty. The decision does not create a new manner of calculating permanent disability or "an exception that swallows the Schedule." It requires application of the Guides as written, including the instructions on its proper use. As discussed, if the chapter applicable to the injury under scrutiny is disregarded by the examining physician without a sufficient evidentiary basis, the physician's **[***44]** conclusions will necessarily be rejected.

Conclusion

By using the word "incorporate" and retaining a prima facie standard for the introduction of the PDRS ratings, the Legislature obtained a more **[*830]** consistent set of criteria for medical evaluations while allowing for cases that do not fit neatly into the diagnostic criteria and descriptions laid out in the Guides. The Guides itself recognizes that it cannot anticipate and describe every impairment that may be experienced by injured employees. To accommodate those complex or extraordinary cases, it calls for the physician's exercise of clinical judgment to evaluate the impairment most accurately, even if that is possible only by resorting to comparable conditions described in the Guides. The PDRS has expressly incorporated the entire Guides, thereby allowing impairment in an individual case to be assessed more thoroughly and reliably.

Disposition

The decision of the WCAB is affirmed.

Premo, Acting P. J., and Duffy, J., concurred.

On September 1, 2010, the opinion was modified to read as printed above. Petitioner's petition for review by the Supreme Court was denied November 10, 2010, S186777.

End of Document

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The parties subsequently obtained two supplemental reports from Dr. Nathan. In his first supplemental report dated December 22, 2012, [Defendant's Exhibit "C"] on pages one to two, Dr. Nathan wrote the following:

> "It is noted in the Rolda case there is a four step analysis to determine whether or not a psychiatric injury is compensable or to be barred by Labor Code [§] 3208.3(b) as having been caused by a lawful, nondiscriminatory personnel action. The determination that must be made as to the actual events of the employment is a legal determination that is deferred to the trier of fact. However, the determination establishing the actual events of employment as being the predominant cause is a medical decision. I can state with reasonable medical probability it was the actual events of employment of the applicant's employment that were predominant in regard to the applicant's injury to his psyche.
>
> It is then to be determined by the trier of fact whether any of the actual employment events or the personnel actions were lawful, nondiscriminatory and in good faith. If the trier of facts [sic] determined the personnel actions were lawful, nondiscriminatory and in good faith, then it would be my opinion the applicant did not sustain a work-related injury, however the converse would be true.
>
> The fourth part of the Rolda Decision requires a medical determination as to whether or not the personnel actions were the substantial cause, i.e., 35-40% of the psychiatric injury. Perhaps I have misunderstood what you are asking for. In my report given the numerous examples which the applicant cited as described in the History of Individual Injury section of my report which are clearly spelled out, I did not conclude these were personnel actions. Therefore, I did not defer this issue to the trier of fact."
>
> Therefore I am puzzled why I am being asked to comment upon the issue of Rolda."

In his second supplemental report dated January 22, 2013, [Defendant's Exhibit "D"] on page five, Dr. Nathan wrote the following:

> "I would urge the trier of fact, no matter what decision they may reach, no matter how credible they may consider the applicant in regard to describing the events of his employment, to take in consideration the applicant's total lack of credibility in regard to his description of what transpired at the time of my examination. Under no circumstances would I suggest the trier of fact consider this applicant to be one hundred percent credible and reliable."

evidence that actual events of employment predominantly caused the psychological injury.

Also, pursuant to Labor Code § 3208.3(h), an injured worker will be barred from receiving compensation for stress and/or any physiological manifestations substantially caused by legitimate, good faith, personnel actions. [County of San Bernardino v. Workers' Comp. Appeals Bd. (McCoy) (2012) 77 Cal. Comp. Cases 219, 221]

The multilevel analysis to establish compensability for claims of injury based on personnel actions, in accordance with Rolda v. Pitney Bowes, Inc. (2001) 66 Cal. Comp. Cases 241, 247 (en banc), is as follows:

(1) whether the alleged psychological injury involves actual events of employment, a factual/legal determination;

(2) if so, whether such actual events were the predominant cause (i.e., accounting for 51% or more) of the psychological injury, a determination which requires medical evidence;

(3) if so, whether any of the actual employment events were personnel actions that were lawful, nondiscriminatory and in good faith, a factual/legal determination; and

(4) if so, whether the lawful, nondiscriminatory, good faith personnel action were a "substantial cause" (i.e., accounting for at least 35% to 40%) of the psychological injury, a determination which requires medical evidence.

A "personnel action" is action by or attributable to the employer, if done by one whom has authority over the injured employee, in managing its business that includes but is not limited to reviewing, criticizing, demoting, or disciplining the injured worker. [Larch v. Contra Costa County (1998) 63 Cal. Comp. Cases 831, 833] As set forth in City of Oakland vs. Workers' Comp. Appeals Bd. (Cullet) (2002) 67 Cal. Comp. Cases 705, 709:

> "[T]he Legislature's 'good faith personnel action' exemption is meant to furnish an employer a degree of freedom in making its regular and routine personnel decisions (such as discipline, work evaluation, transfer, demotion, layoff, or termination). If a regular and routine personnel decision is made and carried out with subjective good faith and the employer's conduct meets the objective reasonableness standard, [§] 3208.3's exemption applies." (footnote excluded)

Finally, an injured worker's subjective misperception of harassment will not constitute actual events of employment. [See Verga v. Workers' Comp. Appeals Bd. (2008) 73 Cal. Comp. Cases 63, 72 (the WCAB found that an applicant's subjective misperception of harassment based on the disdainful reaction of her co-workers to her mistreatment of them by being rude, inflexible, easily upset, and demeaning toward them was found not to constitute actual events of employment; see also

****

State of California

Department of Insurance

CONSUMER INSURANCE FRAUD REPORTING FORM

CDI-008 (Rev. 6/2015)

This form is designed to be used by members of the general public and their representatives. If you are employed in the insurance industry you must use Form FD-1 to make your report. Under California Insurance Code Section 1879.5, no person shall be subject to civil liability for filing a good faith report of suspected insurance fraud to the Department of Insurance.

SECTION 1 – REPORTING PARTY

☐ Anonymous Date _____

Last Name _____ First Name _____

Email Address _____

Company Name _____ DBA _____

Street Address _____ City _____

State _____ Zip Code _____ Contact Phone # _____

SECTION 2 – INSURANCE FRAUD INFORMATION (Please Provide Known Information)

Insurance Company(s) _____

Policy # _____ Claim # _____

Date of Loss _____ Is Fraud Still On Going? ☐ Yes ☐ No

Location of loss: City _____ Zip Code _____

Person listed below is: ☐ Insured ☐ Claimant ☐ Suspect ☐ Other

Last Name _____ First Name _____

Street Address _____ City _____

State _____ Zip Code _____ Phone # _____

Company Name _____ DBA _____

Person listed below is: ☐ Insured ☐ Claimant ☐ Suspect ☐ Other

Last Name _____ First Name _____

Street Address _____ City _____

State _____ Zip Code _____ Phone # _____

Company Name _____ DBA _____

If you have additional names, enter them in the Summary Section on the next page.

SECTION 3 – This Information Has Also Been Referred To:

Has an insurance company been notified of this activity? If yes, listed company _____ ☐ Yes ☐ No

Has a law enforcement agency been notified of this activity? If yes, listed agency(s) _____ ☐ Yes ☐ No

Has a District Attorney's Office been notified of this activity? If yes, listed county _____ ☐ Yes ☐ No

Have other agency(s) been notified of this activity? If yes, listed agency(s) _____ ☐ Yes ☐ No

State of California

Department of Insurance

CONSUMER INSURANCE FRAUD REPORTING FORM

CDI-008 (Rev. 6/2015)

SECTION 4 – SUMMARY

Please describe what fraud activity you wish to report and include answers to the following questions, if known:

Who are the persons committing the fraud?

When & where did the fraud occur?

What is the name of the insured if different than the suspect?

Include names of others who can corroborate this information.

Is anyone in the insurance industry aware of what is occurring?

If you wish to report something that was not covered by these questions, please include that information in your summary.

If you have additional information that does not fit on the space below, please include an additional pages.

Print form and mail to:
Department of Insurance, Fraud Division, 9342 Tech Center Drive, Suite 100, Sacramento, CA 95826 or save form and email completed form to Fraud@insurance.ca.gov

For filing a good faith report of suspected insurance fraud to the Department of Insurance under California Insurance Code Section 1879.5, no person shall be subject to civil liability.

****

Qualified Medical Evaluator Complaint Form

Department of Industrial Relations
Division of Workers' Compensation - Medical Unit
P. O. Box 71010
Oakland, CA 94612

Instructions for Completing this Complaint Form

1. Legibly print or type all information.

2. Provide the name of the Qualified Medical Evaluator and the date of the evaluation.

3. Provide the address where the evaluation was performed.

4. If you are complaining about the contents of the report or the way the evaluation was conducted, please include the medical report of the QME, if available.

5. Please sign and date the complaint form.

NOTICE: Except for the name of the physician, the remainder of the information requested is voluntary; however, the failure to provide the requested information may delay or prevent the investigation of your complaint. Please provide as much information as possible in your complaint. The Division of Workers' Compensation will use the information in your complaint in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies.

Qualified Medical Evaluator Complaint Form

Department of Industrial Relations
Division of Workers' Compensation - Medical Unit
P. O. Box 71010
Oakland, CA 94612

(For DWC use only)

COMPLAINT AGAINST

Physician's First Name _____ Physician's Last Name _____

Address where the Evaluation took place _____

City _____ Zip Code _____ Phone Number _____

Date of Evaluation _____ QME Panel Number _____

Panel Qualified Medical Evaluation ☐ Agreed Medical Evaluation ☐

COMPLAINANT

First Name _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Daytime Phone Number _____ Fax Number _____ E-mail Address _____

If you are making a complaint and you are not the injured worker, please list the name of the injured worker.

Name of Injured Worker: _____

INFORMATON ABOUT THE CLAIM

If you are the injured worker, please list the name of the insurance company/employer and the name and telephone number of your claims adjuster.

Name of Claims Adjuster _____ Phone Number of Claims Adjuster _____

Insurance Company or Employer _____ Claim Number _____

If your complaint involves an examination performed by a Qualified Medical Examiner in a case pending before the Workers' Compensation Appeals Board, please list the case and the case number. If the WCAB has held a hearing or issued any orders about this examination, please attach the minutes of hearing or the Board order to this complaint.

Case Name _____

Case Number(s) _____

GIVE US THE DETAILS LOF YOUR COMPLAINT

Please list the details of your complaint and attach any documents that you believe would be useful for the investigation. Use as many additional sheets paper as necessary to tell us about your complaint.

Date: _____

_____
Signature

****

AUDIT COMPLAINT FORM

IF YOU WANT THIS COMPLAINT TO BE KEPT CONFIDENTIAL, PLEASE MARK THIS BOX: ☐

DIR PRIVACY NOTICE: The Department of Industrial Relations, Division of Workers' Compensation uses the information in your complaint (1) to monitor workers' compensation claims administrators; (2) to assist DWC and other government agencies in general civil and criminal law enforcement; and (3) to conduct research on the workers' compensation system. **If you indicate that you want your complaint kept confidential, the Audit Unit will not share your complaint with any party named in your complaint.** If you do not request confidentiality, the Audit Unit may share your complaint with the claims administrator. Please note that your complaint and your workers' compensation claim information cannot be disclosed to the public under the Public Records Act. If you have questions about this notice please write to Privacy@dir.ca.gov.

Claims administrator / Company name	Injured worker name
Claims adjuster name (if applicable)	Claim number
Claims administrator city location (if known)	Date of injury
Date or period of violations	Employer

SPECIFIC DETAILS OF COMPLAINT

Describe the nature of the complaint, being as specific as possible. For example, late payments of temporary or permanent disability (the number of late payments, if known), failure to pay temporary or permanent disability, or 10% self- imposed penalties for late payments (indicate the periods not paid, if known), failure to pay or object to medical treatment or medical-legal bills, failure to investigate a claim, unsupported denial of liability for a claim, et al. Please attach copies of supporting documentation, if available.

Complainant (name & title) _____ Date _____

Address, city, state, zip code _____ Email: _____

****

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

DOMINGA FRIAS, *Applicant*

vs.

CANCUN TAQUERIA INC. AND ROSTIZERIA INC.;
REPUBLIC UNDERWRITERS INSURANCE COMPANY,
administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, *Defendants*

Adjudication Number: ADJ10371478
San Francisco District Office

OPINION AND ORDERS DENYING APPLICANT'S PETITION FOR DISQUALIFICATION, GRANTING PETITION FOR REMOVAL AND DECISION AFTER REMOVAL

On August 1, 2022, applicant's attorney (petitioner) filed a Petition for Disqualification (Petition) seeking to disqualify the workers' compensation administrative law judge (WCJ) from the proceeding, based upon the appearance of bias stemming from the issuance of an Order on July 29, 2022. By the Order, the WCJ denied petitioner's request to hold a hearing electronically, rather than in person, in order avoid the risk of exposing petitioner's father to COVID-19. (Order Denying Request for Electronic Hearing, July 29, 2022.)

In the Petition, petitioner claims that the WCJ violated his right to due process by issuing the Order without a hearing, preventing him from presenting evidence of his father's health, as well as evidence that defense counsel had allegedly consented to the electronic hearing. Petitioner argues that this evidence would have established good cause to grant his request for the electronic hearing, and that the WCJ's failure to consider this evidence prior to issuing the Order created the appearance of bias, such that disqualification is warranted.

No answer was received. The WCJ filed a Report and Recommendation on Petition for Disqualification (Report), recommending that the Petition be denied. The WCJ states that she had no bias against petitioner or his client (applicant), and that the request was denied based upon the failure to comply with the Appeals Board Rules governing requests for electronic hearings, as well as the fact it was made at the last minute.

We have considered the record in this matter, as well as the allegations of the Petition and the contents of the Report with respect thereto. Upon review, we will deny the petition for disqualification, as it fails to demonstrate an appearance of bias. However, we conclude that, in the interests of due process, the petition should be treated as a petition for removal. For the reasons discussed below, we will grant removal, rescind the WCJ's July 29, 2022 Order, and return the matter to the trial level for further proceedings consistent with this decision.

FACTUAL BACKGROUND

On July 12, 2022, defendants filed a declaration of readiness to proceed (DOR) on the issue of a medical-legal exam. The matter was set for an expedited hearing on the matter for August 1, 2022.

On July 29, 2022, petitioner filed a letter petition addressed to the WCJ, stating: "ALL PARTIES JOINTLY REQUEST LIFE-SIZE BY AGREEMENT DUE TO HEALTH CONCERNS." (Report, p. 2.) Attached to the petition was a letter from Lisa Tsang, M.D., addressing the health of petitioner's father, as well as an email string with a date range of July 18-19, 2022 between petitioner and defense counsel from the Law Offices of Park Guenthart, indicating the latter's consent to hold the expedited hearing via Lifesize. (Report, p. 2.) A proof of service attached to the letter petition stated that service was made to "WCAB by EAMS" and "Park by email." (Report, p. 4.)

The same day, the WCJ issued the Order denying petitioner's request for the electronic hearing. The Order stated, in full:

> Applicant, through her counsel, having filed on July 29, 2022 an unverified letter requesting the expedited hearing on August 1, 2022 be held virtually, indicating that defendant is in agreement with the request, and
>
> IT APPEARING THAT the request fails to comply with Board Rules 10816 and 105[10],
>
> IT IS HEREBY ORDERED that the request for an electronic trial be, and it hereby is, DENIED.

(Order, July 29, 2022.)

On August 1, 2022, petitioner filed the instant petition seeking to disqualify the WCJ from the proceeding.

DISCUSSION

In the Petition, petitioner contends that disqualification is warranted based on the appearance of bias. Specifically, petitioner claims:

> [Petitioner's] father is at high risk for COVID. [Petitioner's] father has a doctor, Dr. Tsang, seeking accommodation that [petitioner] not appear in enclosed conference rooms.
>
> Defendants had agreed to a Lifesize Trial.
>
> * * *
>
> A reasonable person would find that denying Lifesize without comment on the health of [petitioner's] father and without comment on Defendant's consent to Lifesize is apparent bias. There has been no due process study of the medical evidence and the defendant's consent...The above actions are sufficient grounds to disqualify the trial judge for purposes of this trial.

(Petition, pp. 1, 3.)

Due process requires a fair hearing before a neutral, unbiased decision maker, including in administrative proceedings. (*Robbins v. Sharp Healthcare* (2006) 71 Cal.Comp.Cases 1291, 1306 (*Robbins*), citing *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1024-1027 (*Haas*).) Due process is violated where there is even an appearance of bias or unfairness in administrative hearings. (*Haas,* at p. 1034.) The "appearance of bias" test is "an objective one, i.e., would a reasonable person with knowledge of the facts entertain doubts concerning the WCJ's impartiality." (*Robbins,* at p. 1303.)

The WCJ denies that her ruling was based upon bias. (Report, p. 3.) Instead, the WCJ explains that she denied the request because it failed to comply with the WCAB Rules of Practice and Procedure governing requests for electronic hearings, specifically, WCAB Rules 10816, 10510, and 10625. (Report, pp. 3-4.) WCAB Rule 10816 states: "If a party intends to appear electronically at any hearing, they shall file a petition showing good cause pursuant to rule 10510." (Cal. Code Regs., tit. 8, § 10816.) WCAB Rule 10510 requires, among other things, that "a request for action by the [WCAB]...shall be made by petition," and that "[a]ll petitions and answers shall be verified under penalty of perjury...." (Cal. Code Regs., tit. 8, § 10510.) WCAB Rule 10625 addresses proof of service, and states: "Proof of service" means a "dated and verified declaration identifying the document(s) served and the parties who were served, and stating that the service has been made and the method by which it has been made....If a document is served electronically,

the proof of service must also state the names and email addresses of the person serving electronically and the person served electronically." (Cal. Code Regs., tit. 8, § 10625.)

In her Report, the WCJ explains that she denied petitioner's request because it did not conform to WCAB Rule 10816, where the request: 1) was a "letter," rather than a pleading in accordance with WCAB Rule 10510, and 2) was not verified in accordance with WCAB Rule 10510. The WCJ also states that the letter lacked valid proof of service in accordance with WCAB Rule 10625. The WCJ explains that, although it did appear that defense counsel's law office was served via email, the proof of service failed to provide the specific name(s) and email address(es) of the person(s) serving the document and the person(s) served. (Report, p. 4.)

Upon review, we conclude that the WCJ's decision to deny the request for an electronic hearing was based upon a misunderstanding of the WCAB Rules of Practice and Procedure, rather than bias. (Report, pp. 3-4.) Although petitioner's letter request for an electronic hearing lacked the formality typically associated with such a request under our rules, the WCJ was mistaken that anything less than strict compliance with these rules was grounds for denying the request. The WCAB Rules "serve the convenience of the tribunal and the [litigants] and facilitate the proceedings. They do *not* deprive the tribunal of the power to dispense with compliance when the purposes of justice require it, particularly when the violation is formal and does not substantially prejudice the other party." (*Rubio v. Workers' Comp. Appeals Bd.* (*Rubio*) (1985) 165 Cal.App.3d 196, 200 [50 Cal.Comp.Cases 160], italics added.) "[I]t is better to dispose of '...causes upon their substantial merits, rather than with strict regard to technical rules of procedure. The discretion of the court ought always to be exercised in such manner as will subserve rather than impede or defeat the ends of justice.' [Citation.]" (*Carrara v. Carrara* (1953) 121 Cal.App.2d 59, 63 (*Carrara*).)

When we created these rules of procedure, we did not intend to create a barrier to electronic hearings, or that failure to technically comply with these rules would constitute grounds to deny a request for lack of good cause. Instead, we adopted these rules to ensure that no party is surprised or prejudiced by such a request from the other side. (See *Fortich v. Workers' Comp. Appeals Bd.* (1991) 233 Cal.App.3d 1449, 1452-1453 [56 Cal.Comp.Cases 537] ["[A] fundamental requirement of due process...is notice reasonably calculated [] to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections."].) As noted in the WCJ's Report, petitioner's request for an electronic hearing appears to have been sent *and* consented to by defense counsel, and defense counsel has not filed anything in the proceeding

claiming otherwise. (Report, pp. 2, 4.) Thus, in denying petitioner's request, the WCJ erroneously exalted form over substance, requiring strict technical compliance with our rules of procedure, despite the absence of prejudice to the other side and at the expense of issuing a decision on the merits. (*Rubio, supra,* 165 Cal.App.3d at p. 200; *Carrara, supra,* 121 Cal.App.2d at p. 63.) That said, such a decision did not create an appearance of bias. "A judge's errors on questions of law, no matter how gross, do not constitute bias or prejudice or a disqualification to proceed with the trial of the case in which the errors were made. [citations] Erroneous rulings against a litigant, even when numerous and continuous, form no ground for a charge of bias or prejudice, especially when they are subject to review." (*Mackie v. Dyer* (1957) 154 Cal.App.2d 395, 400.) Based on the foregoing, we disagree with petitioner that there is an appearance of bias that would justify disqualifying the WCJ from the proceeding.

We do, however, agree with petitioner that the WCJ violated his right to due process by issuing the Order without a hearing. All parties to a workers' compensation proceeding retain the fundamental right to due process and a fair hearing under both the California and United States Constitutions. (*Rucker v. Workers' Comp. Appeals Bd.* (*Rucker*) (2000) 82 Cal.App.4th 151, 157-158 [65 Cal.Comp.Cases 805].) A fair hearing is "...one of 'the rudiments of fair play' assured to every litigant...." (*Id.* at p. 158.) A fair hearing includes but is not limited to the opportunity to call and cross-examine witnesses; introduce and inspect exhibits; and to offer evidence in rebuttal. (*Gangwish v. Workers' Comp. Appeals Bd.* (2001) 89 Cal.App.4th 1284, 1295 [66 Cal.Comp.Cases 584].)

The lack of a hearing prevented either party from exercising their right to call witnesses, cross-examine witnesses and/or introduce evidence in support of their positions, which is a deprivation of the constitutional guarantee of due process of law. (*Rucker, supra*, 82 Cal.App.4th at p. 157.) In order to address this due process issue, we will exercise our discretion under Labor Code section 5310 and remove the case to ourselves. (Lab. Code, § 5310.)

Removal is an extraordinary remedy rarely exercised by the Appeals Board. (*Cortez v. Workers' Comp. Appeals Bd.* (*Cortez*) (2006) 136 Cal.App.4th 596, 600, fn. 5 [71 Cal.Comp.Cases 155]; *Kleemann v. Workers' Comp. Appeals Bd.* (*Kleemann*) (2005) 127 Cal.App.4th 274, 281, fn. 2 [70 Cal.Comp.Cases 133].) The Appeals Board will grant removal when substantial prejudice or irreparable harm will result if removal is not granted. (Cal. Code Regs., tit. 8, § 10955(a); see also *Cortez, supra; Kleemann, supra.*) Also, it must be established that reconsideration will not

be an adequate remedy if a final decision averse to the petitioner ultimately issues. (Cal. Code Regs., tit. 8, § 10955(a).)

A violation of due process obviously causes substantial prejudice and irreparable harm that reconsideration cannot cure. Moreover, the WCJ failed to issue an Opinion on Decision, therefore is no meaningful opportunity to review the Order. (Lab. Code, § 5313; *Hamilton v. Lockheed Corporation* (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Board en banc).)

Consequently, although we will deny the petition for disqualification, we will treat the petition as a petition for removal and grant removal. In granting removal, we will rescind the WCJ's July 29, 2022 Order and return the matter to the trial level for further proceedings consistent with this decision.

For the foregoing reasons,

IT IS ORDERED that the Petition for Disqualification of the WCJ is **DENIED.**

IT IS FURTHER ORDERED that the Petition for Disqualification of the WCJ is **GRANTED** as a Petition for Removal.

IT IS FURTHER ORDERED, as the Decision After Removal of the Workers' Compensation Appeals Board, that the Order issued on July 29, 2022 by the WCJ is **RESCINDED** and this matter **RETURNED** to the trial level for further proceedings consistent with this decision.

WORKERS' COMPENSATION APPEALS BOARD

/s/ ANNE SCHMITZ, DEPUTY COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MARCH 10, 2023

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

DOMINGA FRIAS
KENNETH MARTINSON
PARK GUENTHART

AH/*cs*

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date.
CS

****

IN THE COURT OF APPEAL

STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

JUVENAL TORRES ZAMORA

Petitioner,

vs.

MAYA RESTAURANT;

EMPLOYERS COMPENSATION INSURANCE COMPANY;

WCAB.

Respondents.

Civil No.:

WCAB Case No.: ADJ10586384

PETITION FOR WRIT OF REVIEW

KENNETH D. MARTINSON SBN: 199799

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San Bruno, CA 94066

(408) 375 - 8135

kennethmesq@msn.com

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Hamilton v. Lockheed Corporation (2001) 66 Cal.Comp.Cases 473 (Appeals Bd. en banc) (Hamilton)

TABLE OF EXHIBITS

1. Joint 109, Report of QME Nicole Chitnis, M.D., December 1, 2021

2. Minutes of Hearing, August 23, 2022

3. Petitioner's Petition for Reconsideration, August 9, 2023

4. Pre-Trial Conference Statement, April 7, 2022

5. Opinion and Order Denying Petition for Reconsideration, October 9, 2023

6. Report and Recommendation on Petition for Reconsideration, August 23, 2023

7. Joint 110, Transcript of Deposition of QME Nicole Chitnis, M.D., March 7, 2022

8. Minutes of Hearing, November 15, 2022

9. Findings of Fact and Award, July 21, 2023

TO THE HONORABLE PRESIDING JUSTICE AND TO THE HONORABLE ASSOCIATE JUSTICES OF THE COURT OF APPEAL OF THE STATE OF CALIFORNIA, FIRST APPEALLATE DISTRICT

Petitioner, Juvenal Torres Zamora, hereby petitions this court for a Writ of Review to inquire into and determine the lawfulness of the Opinion and Order Denying Petition for Reconsideration issued by the Workers' Compensation Appeals Board on October 9, 2023.

In support of its verified petition, Petitioner sets forth the following salient facts and procedural history.

I.

Petitioner, Juvenal Torres Zamora, presented for a medical examination, requested by the insurer and the defendant. Petitioner does not proficiently speak or understand the English language. The purpose of the medical exam was to establish compensation owed by the insurer to Petitioner. The insurer requested Petitioner be examined by Nicole Chitnis M.D. on November 15, 2021. Joint 109.

II.

Two different interpreters appeared at Dr. Chitnis' exam, namely Alicia Pagliere and Eva Ponce. Id. at p. 2. According to Dr. Chitnis, "Alicia Pagliere helped with current complaints and physical examination. The [Petitioner] expressed difficulty understanding Alicia Pagliere..." Ibid. [edited]

III.

For purposes of determining compensation, Alicia Pagliere, was charged with interpreting in a language that the Petitioner understood. Ca. Evid. Code § 755.5. The medical examination and report were conducted in violation of

the Government Code because Alicia Pagliere did not interpret the Spanish Language in a way that Petitioner could understand. Ibid.; citing Article 8, Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

IV.

Pursuant to the violation, Petitioner has argued that Dr. Chitnis' evidence is inadmissible. Id. Title 2(c)(a). Petitioner's Petition for Reconsideration, August 9, 2023 at pp. 4-5 [attached]; Minutes of Hearing, August 23, 2022, p. 3; Pre-Trial Conference Statement, April 7, 2022, p. 5; see in Ca. Evid. Code § 755.5 "(c) The record of, or testimony concerning, any medical examination conducted in violation of subdivision (a) shall be inadmissible in the civil action for which it was conducted or any other civil action."

V.

The WCAB has failed to address Ca. Evid. Code § 755.5. The WCAB issued their Opinion and Order Denying Petition for Reconsideration without any comment on Ca. Evid. Code § 755.5. Opinion and Order Denying Petition for Reconsideration, October 9, 2023.

VI.

Instead, the WCAB incorporated the Trial Judge's comments in his Report and Recommendation on Petition for Reconsideration, especially as to interpreting difficulties. Report and Recommendation on Petition for Reconsideration, August 23, 2023 (R and R) incorporated in Opinion, supra.

VII.

The WCAB has held that the interpreting difficulties were legally and substantially cured by Dr. Nicole Chitnis and by WCJ Lawrence Keller. R

and R, pp. 5-6. The WCAB held that Dr. Chitnis' reporting was substantial evidence to support an Award. Ibid.

VIII.

WHEREFORE Petitioner prays that:

1. A Writ of Review issue from this Court of Appeal to the Workers' Compensation Appeals Board of the State of California commanding it to certify fully to this Court at a specified time and place, the records and proceedings on the matter, so that this Court may inquire into the lawfulness of the decision of the Workers' Compensation Appeals Board that found that substantial evidence is present to support the Findings of Fact and Award dated July 21, 2023; and
2. The record and proceedings of this cases shall be fully heard and considered by this Court and aforementioned Findings of Fact and Award be annulled, vacated and set aside, or, in the alternative, that this matter be remanded to the trial level; and
3. Such other relief as this Court deems proper.

Cal Lab Code § 5952

§ 5952. The review by the court shall not be extended further than to determine, based upon the entire record which shall be certified by the appeals board, whether:

(a) The appeals board acted without or in excess of its powers.

(b) The order, decision, or award was procured by fraud.

(c) The order, decision, or award was unreasonable.

(d) The order, decision, or award was not supported by substantial evidence.

(e) If findings of fact are made, such findings of fact support the order, decision, or award under review.

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IN THE COURT OF APPEAL

STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

JUVENAL TORRES ZAMORA

Petitioner,

vs.

MAYA RESTAURANT;

EMPLOYERS COMPENSATION INSURANCE COMPANY;

WCAB.

Respondents.

Civil No. :

WCAB Case No.: ADJ10586384

Memorandum of Points and Authorities in Support of Petition for Writ of Review

Standard of Review

When considering a Petition for Review, the "Court must determine whether the evidence, when viewed in light off the entire record, supports the Award of the Workers' Compensation Appeals Board." *Kuelen v. WCAB* (1998) 866 Cal.App. 4th 1089, 1095-6.

QUESTIONS PRESENTED

I. CAN THE WCAB, A STATE AGENCY, DENY DUE PROCESS AND EQUAL PROTECTION TO PETITIONER WHO HAS LIMITED ENGLISH SKILLS?

II. CAN THE WCAB, A STATE AGENCY, UTILIZE MEDICAL EVIDENCE THAT IS BASED ON INACCURATE SPANISH-ENGLISH INTERPRETING?

STATEMENT OF MATERIAL FACTS

Petitioner, Juvenal Torres Zamora, presented for a medical examination, with Dr. Nicole Chitnis on November 15, 2021 as requested by the insurer and the defendant. Joint 109. Two different interpreters appeared at Dr. Chitnis' exam, namely Alicia Pagliere and Eva Ponce. Id. at p. 2. According to Dr. Chitnis, "Alicia Pagliere helped with current complaints and physical examination. The [Petitioner] expressed difficulty understanding Alicia Pagliere..." Ibid. [edited]

For purposes of determining compensation, Alicia Pagliere, was charged with interpreting in a language that the Petitioner understood. Ca. Evid. Code § 755.5. The medical examination and report were conducted in violation of the Government Code because Alicia Pagliere did not interpret the Spanish Language in a way that Petitioner could understand. Ibid.; citing Article 8, Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

Petitioner has argued that Dr. Chitnis' evidence is inadmissible. Id. Title 2(c)(a). Petitioner's Petition for Reconsideration, August 9, 2023 at pp. 4-5 [attached]; Minutes of Hearing, August 23, 2022, p. 3; Pre-Trial Conference Statement, April 7, 2022, p. 5; see in Ca. Evid. Code § 755.5 "(c) The record of, or testimony concerning, any medical examination conducted in violation of

subdivision (a) shall be inadmissible in the civil action for which it was conducted or any other civil action."

The WCAB failed to address Ca. Evid. Code § 755.5. The WCAB issued their Opinion and Order Denying Petition for Reconsideration without any comment on Ca. Evid. Code § 755.5. Opinion and Order Denying Petition for Reconsideration, October 9, 2023.

Instead, the WCAB incorporated the Trial Judge's comments in his Report and Recommendation on Petition for Reconsideration, especially as to interpreting difficulties. Report and Recommendation on Petition for Reconsideration, August 23, 2023 (R and R) incorporated in Opinion, supra.

The WCAB held that the interpreting difficulties were legally and substantially addressed by Dr. Nicole Chitnis and by WCJ Lawrence Keller. R and R, pp. 5-6. The WCAB held that Dr. Chitnis' reporting was substantial evidence to support an Award. Ibid.

In response to the Opinion and Order from the WCAB, Petitioner files this appeal.

Arguments and Authorities

I. THE WCAB, A STATE AGENCY, CAN NOT DENY DUE PROCESS AND EQUAL PROTECTION TO PETITIONER, A LIMITED ENGLISH SPEAKER

The Petitioner, a limited English speaker, has an absolute right to Due Process in workers' compensation proceedings. *Rucker v. Workers' Comp. Appeals. Bd.* (2000) 82 Cal.App.4th 151, 157-8. Due Process vis-à-vis language rights and language access is favored. Government Code € 68560(e). Non-English speakers must be provided equal justice. Ibid.

In the instant case, Petitioner submitted to a medical examination for compensation on November 15, 2021 with Dr. Nicole Chitnis, for purposes of establishing the value of his injury claim. Joint Exhibit 109. In the report, Dr. Chitnis reports, "[t]he patient expressed difficulty understanding Alicia Pagliere but communication was further clarified by Eva Ponce." Id at p. 2 [edited]. There were 2 interpreters present at the medical exam for compensation. Ibid. Alicia Pagliere, the interpreter that was difficult to understand, assisted with the Petitioner's complaints and physical examination. Ibid.

At deposition, Dr. Chitnis acknowledged that Petitioner felt "he was ... not able to communicate everything to me." Joint Exhibit 110. P. 20, lines 17 to 25. The uncontroverted Trial Testimony of Petitioner was that "he had difficulty communicating through one of the interpreters ... The [Petitioner] believes that Alicia did not interpret everything he said to Dr. Chitnis." Minutes of Hearing and Summary of Evidence, November 15, 2022, p. 3, lines 23 to 27. [edited].

At deposition, Dr. Chitnis confirmed that Alicia Pagliere, whose interpreting was difficult to understand, conducted about one-third of the medical exam. Joint 110, p. 19, lines 6 to 16. Dr. Chitnis uncontroverted testimony was that one-third of the medical exam for compensation was conducted through Alicia Pagliere, an interpreter that was difficult to understand. Therefore, the Petitioner was denied language access and equal justice because one-third of his medical exam for compensatino was carried out with Alicia Pagliere, the interpreter that was difficult to understand. The Defendants did not satisfy the intention of Government Code € 11435.05 by hiring Alicia Pagliere. The oral interpreting by Alicia Pagliere resulted in inaccurate interpretation and communication between the Petitioner and Dr. Chitnis. Joint Orders at p. 3.

The WCAB failed to address this controversy as raised under Evid. Code € 755.5. Petition for Reconsideration, August 9, 2023, pp. 4-5. The insurer defendant requested the Petitioner to submit to a medical exam. The Defendants is obligated to provide an interpreter at "the examination in a language that the [Petitioner] understands..." Evid. Code 755.5. The Evidence Code further provides that "any medical examination conducted in violation of subdivision (a) shall be inadmissible in the civil action for which it was conducted or any other civil action. Ibid. [edited].

Neither in the Findings of Fact and Award nor in the Opinion and Order Denying Petition for Reconsideration does the WCAB identify and discuss Evid. Code 755.5. The WCAB failed to comply with the strict requirements for an Order. The WCAB did not "make .... findings" and did not determine the "rights of the parties" with respect to Evid. Code 755.5. see Labor Code € 5313.

The WCAB reliance on Dr. Chitnis' Deposition Testimony "that interpreter Eva Ponce was able to correct any deficiencies in the initial interpreting by Alicia Pagliere" is not compliant with Language Access, Equal Justice and Ca. Evid. Code € 755.5. Report and Recommendation on Petition for Reconsideration, (R and R), p. 6. At Deposition, Dr. Chitnis admitted "she is not a Spanish speaker herself" and that she "believed" that the "Petitioner [was] comfortable in the communication. Ibid.

Dr. Chitnis' field of expertise is medicine; Dr. Chitnis expertise is not Spanish. Dr. Chitnis has no expert authority over Spanish, especially as to whether the communication was comfortable or accurate. As a non-expert in Spanish, Dr. Chitnis' opinions on Spanish communication and interpretation have no authority. *Place v. Workers' Comp. Appeals. Bd. (Place)* (1970) 35

Cal.Comp.Cases 525. Dr. Chitnis simply speculated and guessed about the accuracy of the communication between Petitioner and Alicia Pagliere. As a result, Dr. Chitnis' medical evidence and testimony have no "firm foundation of fact" since Alicia Pagliere did about one-third of the interpreting and there is no showing that Alicia Pagliere's interpreting was accurate and in compliance with Government Code € 68560(e), Ca. Evid. Code € 755.5, Due Process and Equal Protection. *Skip Fordyce, Inc., Workers' Comp. Appeals Bd. (Barry)* (1983) 48 Cal.Comp.Cases 904.

With due deference to the WCAB power and authority, the WCAB's area of expertise is not Spanish. Place (supra). The Opinion and Order Denying Petition for Reconsideration by the WCAB stands on no foundation in Substantial Evidence, Language Access, Language Rights, Due Process and Equal Protection. Dr. Chitnis's reporting upon which the WCAB relies is based on inaccurate interpreting. Petitioner's challenges under Ca. Evid. Code € 755.5 have never been addressed by the WCAB. Labor Code € 5313.

The consequence of the WCAB's reliance on Dr. Chitnis' report that is inaccurately interpreted is a message to non-English speakers that justice is unavailable. The WCAB decision erodes the confidence of non-English speakers in the Court System and further damages the institutional integrity of the Courts. The WCAB's proffered remedies to cure the Language Access, Due Process and Equal Protection violations in this case are untenable.

The WCAB is not an expert in Spanish. Yet the WCAB, a non-Spanish expert, reasoned that the interpreting issues did not undermine Dr. Chitnis' reporting. R and R, p. 6. The WCAB does not hold as one of its enumerated powers the power of a Spanish Language Expert. *Place v. Workers' Comp. Appeals. Bd. (Place)* (1970) 35 Cal.Comp.Cases 525. The WCAB allowed Dr.

Chitnis, a non-Spanish expert, to have final authority over interpreter deficiencies. The WCAB "remain[ed] persuaded by Dr. Chitnis' deposition testimony that interpreter Eva Ponce was able to correct any deficiencies in the initial interpreting by Alicia Pagliere." Ibid.

Further, the WCAB offers a remedy for interpreting deficiencies that does not comply with Evid. Code € 755.5, Language Access, Due Process and Equal Protection. That remedy was to ask the Petitioner to recall verbatim what he said to Alicia Pagliere on November 15, 2021. The WCAB suggested that Petitioner and his Attorney "identify the deficiencies" in Dr. Chitnis' reporting. R and R, p. 6. That is an unconstitutional encumbrance on the Petitioner. California Constitution, article XIV, § 4. The WCAB has unconstitutionally shifted the burden of securing an accurate interpreter to the Petitioner. The burden is on the insurer to secure an accurate interpreter. Ca. Evid. Code € 755.5.

II. THE WCAB, A STATE AGENCY, CANNOT UTILIZE MEDICAL EVIDENCE THAT IS NOT SUBSTANTIAL TO SUPPORT AN ORDER

The WCAB is a state agency. California Law recognizes that non-English speaking persons are owed "equal justice ... for their special needs" in the "administrative law system." Government Code € 68560(e) [edited]. The WCAB, an administrative law system, is prohibited by law from discriminating against persons based on their national origin. Government Code € 11135.

The WCAB denied equal justice to Petitioner by issuing an Opinion and Order Denying Petition for Reconsideration based on medical reporting that lacked accuracy in Spanish interpretation. The impact of Spanish

interpretation that fails Due Process and Equal Protection standards has been stated in the first argument. As a second argument, Petitioner raises that Dr. Chitnis' report is not substantial evidence.

Evidence is not substantial if the expert medical "opinion is based on surmise, speculation, conjecture or guess." *Owings v. Industrial Acc. Com.* (1948) 31 Cal.2d 689, 692. As a non-Spanish expert, Dr. Chitnis surmises, speculates, conjectures and guesses when she affirms the communication difficulties present among the interpreters, the Petitioner and herself were corrected. Joint 109, p. 2; R and R, p.6. Dr. Chitnis' non-Spanish expert opinions on Spanish communications cannot undo the fact that her reporting relied on an inaccurate history and examination. Other than based on speculation, Dr. Chitnis has no scientific, probative or expert basis to declare that the Spanish-English communication was understood. Accordingly, in addition to Dr. Chitnis' reporting being non-compliant with Ca. Evid. Code € 755.5, Dr. Chitnis' reporting is not substantial evidence as it is based on speculative interpreting and communication among Petitioner, Alice Pagliere and Dr. Chitnis. *Hamilton v. Lockheed Corporation* (2001) 66 Cal.Comp.Cases 473, 475-6 (Appeals Bd. en banc) (Hamilton).

The WCAB agrees that, "Medical reports and opinions are not substantial evidence if they ... based on ... inadequate medical histories and examinations ..." Findings of Fact and Award (FFA), p. 21. Citing *Hegglin v. Workers' Comp. Appeals Bd.*, 4 Cal. 3d 162, 169, (1971) Supreme Court in Bank. Utilizing the WCAB's own analysis, Dr. Chitnis' medical reporting and opinions are not substantial evidence because they are grounded in a tortured analysis that Dr. Chitnis' role is that of not only the medical expert but also the Spanish expert.

RELIEF SOUGHT

Wherefore Applicant Attorney prays for: Granting of Writ and Remand to the WCAB with further instructions regarding the issues raised. Petitioner requests a re-examination by Dr. Nicole Chitnis with Eva Ponce.

Respectfully submitted,

Dated November 20, 2023

KENNETH D. MARTINSON

Kenneth Martinson San Bruno

VERIFICATION

I, Kenneth D. Martinson, declare that I have read the attached pleading and know its contents, which are true of my own knowledge, except as to those matters stated on my information and belief and which, I believe to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

10/2/2023 

CERTIFICATE OF WORD COUNT

The word count for this document, according to Word is three thousand five hundred one.

Court of Appeal

State of California

First Appellate District

Certificate of Interested Entities or Persons

Court of Appeal Case Number: to be assigned

Division:

Case Name: Juvenal Torres Zamora v. Maya Restaurant; Employers Compensation Insurance Company

Interested entities or persons are listed below:

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   ATTORNEY FOR DEFENDANT

3. **EMPLOYERS PREFERRED**

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   LEXINGTON, KY 40512

   RESPONDENT INSURANCE COMPANY

4. **MAYA RESTAURANT**

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   SONOMA, CA 95476

   EMPLOYER

5. **JUVENAL TORRES ZAMORA**
   PETITIONER
6. **WORKERS' COMPENSATION APPEALS BOARD**
   RESPONDENT VENUE
7. **WORKERS' COMPENSATION JUDGE KELLER**
   TRIAL JUDGE

I declare, under penalty of perjury, that the foregoing is true and correct.

Date 11/21/2023

Signature of Declarant

CERTIFICATE OF SERVICE

STATE OF CALIFORNIA

I, KENNETH MARTINSON SAN BRUNO
I am a citizen of the United States, a resident of San Mateo County, and am over 18 years of age. I am not a party to the within-entitled action. My business/residence address is KENNETH MARTINSON SAN BRUNO, 851 Cherry Ave Ste 27 100, San Bruno, California. On the date of signature below, I served a copy of the attached

PETITION FOR WRIT OF REVIEW

In this action by at San Bruno, California, addressed as follows:

WCAB
by electronic filing

CALIFORNIA INTERPRETER
By email

Court of Appeal
By email

Mullen
By email

Employers
By email

By Mail

Maya Restaurant
101 E Napa St
Sonoma, CA 95476

I declare, under penalty of perjury, that the foregoing is true and correct.

Date 11/2,/2023 _____
Signature of Declarant

Fw: ADJ10586384 PETITION FOR WRIT OF REVIEW

Kenneth Martinson <kennethmesq@msn.com>
Tue 11/21/2023 2:00 PM

To:Kenneth Martinson <kennethmesq@msn.com>;California Interpreters <info@cainterpreters.com>;recon unit <wcabgrantforstudy@dir.ca.gov>;Juvenal Torres Zamora DA nothing to EX <kgarcia@mulfil.com>;ssenane@employers.com <ssenane@employers.com>

1 attachments (2 MB)
ADJ10586384 PETITION FOR WRIT OF REVIEW.pdf;

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The California Constitution declares that Workers' Compensation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character.

From: Kenneth Martinson <kennethmesq@msn.com>
Sent: Tuesday, November 21, 2023 1:55 PM
To: Kenneth Martinson <kennethmesq@msn.com>
Subject: ADJ10586384 PETITION FOR WRIT OF REVIEW

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STATE OF CALIFORNIA

WORKERS' COMPENSATION APPEALS BOARD

JUVENAL TORRES ZAMORA Applicant, vs. MAYA RESTAURANT; EMPLOYERS COMPENSATION INSURANCE COMPANY Defendants	Case No.: ADJ10586384 Hearing Date: **PETITION FOR RECONSIDERATION LC 5803**

COMES NOW, Applicant with a Petition for Reconsideration. Applicant requests Reconsideration:

1. The Award of 07/21/2023 is not substantial evidence to support a decision because the Award violated Due Process and Equal Protection. The Order is based on medical evidence from musculoskeletal QME Dr. Nicole Chitnis whose opinions are not substantial because they rely on inaccurate interpreting resulting in an inaccurate medical history and

examination. Further Dr. Chitnis reporting is speculative because she has not confirmed whether she has ever reviewed 2,898 pp of records.

STATEMENT OF FACTS

1. At Dr. Nicole Chitnis exam in November 2021, 2 Spanish interpreters provided services. Dr. Chitnis testified that she was aware that the Applicant had difficulties understanding the first interpreter, Alicia Pagliere. Ms. Pagliere assisted in the initial 1/3 of the QME interview and exam. Dr. Chitnis further agreed that the Applicant would have difficulty conveying his physical complaints and complying with the physical exam if Alicia Pagliere had been the only interpreter available for the entire interview and exam.

2. Dr. Chitnis further confirmed she has no personal knowledge of what the Applicant was saying in Spanish. Dr. Chitnis confirmed that the Applicant stated that the second interpreter, Eva Ponce, was understood by the Applicant. Dr. Chitnis confirmed that Alicia Pagliere covered the first third of the exam. Dr. Chitnis confirmed that Eva Ponce did the remainder of the examination process.

3. Dr. Chitnis' testimony suggests that one third of the communication and exam conducted by Alicia Pagliere was inaccurate. Dr. Chitnis offered to re-examine the Applicant with Eva Ponce alone. Dr. Chitnis could not identify what part of the applicant's medical history would need to be redone based on 1/3 of the interview and exam having been done by Alicia Pagliere.

4. As of 03/27/2022, Dr. Chitnis stated she had only received 3 medical reports dealing with applicant's medical care since the surgery of 11/03/2020. Dr. Chitnis confirmed she has potentially failed to review 2,898 pp. of medical records.

The Award denies Due Process and Equal Protection because the Award denies Language Justice for the Spanish Speaking Applicant

Applicant does not claim that any party, especially the Judge, intentionally denied Applicant Due Process and Equal Protection by discriminating against the Applicant who is monolingual in Spanish. Nevertheless, the Award discriminates against the Applicant based on his being monolingual in Spanish. The law mandates that the Workers Compensation system, which is administered by the state, shall not discriminate against a person based on his national origin. CA Govt Code Section 11135(a). Further FEHA, now the Civil Rights Department, defines national origin as the individual's "actual or perceived .... linguistic characteristics associated with a national origin group." CCR, tit. 2, div. 4.1, chapter 5, subchapter 2, art. 4, Sect. 11027.1 [edited].

The Award discriminates against the Applicant as a Spanish-speaking person. Dr. Chitnis offered a re-examination of the Applicant since the Applicant "feels that he was ... not able to communicate everything to me." Joint Exhibit 110, p. 20, lines 17 to 25. Dr. Chitnis values accurate communication. The uncontroverted testimony of Applicant is that "he had difficulty communicating

through one of the interpreters. ...The Applicant believes that Alicia [first interpreter] did not interpret everything he said to Dr. Chitnis." SOE, 11/15/2022, p. 3, lines 23 to 27. [edited] Alicia Pagliere, the inaccurate interpreter, provided 1/3 of the interpreting services at Dr. Chitnis interview and exam of November 2021. Joint 110, p. 19, lines 6 to 16. This means that only 2/3 of the interview and exam were conducted with an accurate interpreter, Eva Ponce. Ibid. see LC 4600; Govt. Code 11435.05. The above Labor and Govt. Codes give effect to the Rights to Medical Care, Due Process and Equal Protection.

The Applicant was afforded only 2/3 of his Due Process and 2/3 of his Equal Protection. This translates to a 100% denial of Due Process and Equal Protection. Dr. Chitnis' opinions stand on 2/3 of the medical history and exam. Dr. Chitnis' report is not substantial and can not support an Award. Dr. Chitnis' opinion is based on "surmise, speculation, conjecture or guess." Place v. Workers' Appeals Bd. (Place) (1970) 35 Cal.Comp.Cases 525. Dr. Chitnis is speculating and guessing on the 1/3 of the interview and exam of the Applicant. The Award has no "firm foundation of fact" since 1/3 of the facts relied upon are not accurate because of the inaccurate interpreting of Alicia Pagliere. Skip Fordyce, Inc., v. Workers' Comp. Appeals Bd. (Barry) (1983) 48 Cal.Comp.Cases 904.

Further the Evidence Code diminishes the weight given to Dr. Chitnis' opinions. When the Defendants request the Applicant submit to the examination of Dr. Chitnis, "an interpreter shall be

present to interpret the examination in a language that the [applicant] understands.... any medical examination conducted in violation of subdivision (a) shall be inadmissible in the civil action for which it was conducted or any other civil action." Evid. Code 755.5 [edited].

The judge relies on Dr. Chitnis' opinions on interpreting. The Judge defers to Dr. Chitnis judgement on the interpreting since "in her opinion the patient, the interpreter, and herself were all satisfied with the communication." Opinion, p. 5. Dr. Chitnis is neither a Spanish certified interpreter nor an expert that can comment on the Spanish language. Dr. Chitnis testified she neither speaks Spanish nor has any knowledge of what was being said in Spanish during the exam. Joint 110, p. 18, lines 5 to 9; see Joint 109.

The Judge recites that the Applicant "also did not testify to any information he tried to convey during the evaluation which was not in the report of Dr. Chitnis." Opinion, p. 19, see Joint 109. This begs the question. How can a Spanish Speaking applicant be charged with knowing what was actually conveyed in English? The Applicant is not a certified Spanish interpreter. Dr. Chitnis is not a certified Spanish interpreter. It offends Language Justice, Due Process and Equal Protection to require a Spanish Speaker to accurately understand what was said in English and then to testify as to what was inaccurate in English.

Applicant's testimony that he had difficulty understanding Alicia Pagliere is unimpeached. It violates Due Process and Equal Protection and Govt. Code 11135 when the Judge can be persuaded

by Dr. Chitnis that Due Process and Equal Protection were protected. Without laying out the specific legal how and why, the Judge was persuaded by Dr. Chitnis, not a Spanish expert, "that interpreter Eva Ponce was able to correct any deficiencies in the initial interpreting by Alicia Pagliere." Opinion, p. 26. It is inconsistent for the Judge to simultaneously state he was persuaded by Dr. Chitnis' opinions on interpreting corrections but at the same time state that "Dr. Chitnis's lack of Spanish fluency prevented her from judging the technical accuracy of the interpretation." Ibid.

The Judge's factual finding that the interpreting issues were corrected is "inequitable when viewed in light of the overall statutory scheme." Western Growers Ins. Co. v. Workers' Comp. Appeals Bd. (1993) 58 Cal.Comp.Cases 323; LC 3202; Govt. Code 11135, Federal and State Constitutional protects re Due Process and Equal Protection; article XIV, Sect 4, California Constitution and equal protection under Fourteenth Amendment of the United States Constitution. In effect, the Award denies Due Process and Equal Protection because the Award follows Dr. Chitnis non-expert opinions on the Spanish Language.

If this were extended to all Spanish speaking applicants requiring an interpreter, then the Workers' Compensation System could deny Due Process and Equal Protection to any Spanish-speaking Applicant simply because a Med-legal doctor believed the communication was accurate. The Judge's finding that Dr. Chitnis' opinions are substantial is not supported. Dr. Chitnis testified that Alicia Pagliere

interpreted 1/3 of the interview and exam. Joint 110, p. 19, lines 6 to 16.

Dr. Chitnis could not identify what part of the applicant's medical history and exam would need to be redone based on 1/3 of the interview and exam being done inaccurately by Alicia Pagliere. Joint 110, pp. 22 to 23, lines 2 to 19. Accordingly, Dr. Chitnis reporting is based on "inadequate medical histories and examinations" because there is doubt as to what was actually communicated to Dr. Chitnis by the Applicant. Hegglin v. Workmen's Comp. Appeals Bd. (1971) 36 Cal.Comp.Cases 93. The Judge's Award is not supported by Dr. Chitnis' reporting which "is based on surmise, speculation, conjecture, or guess." Ibid.

The Spanish speaking Applicant has an absolute right to Due Process in workers' compensation proceedings. Rucker v. Workers' Comp. Appeals Bd. (2000) 82 Cal.App.4th 151, 157-158. The Award, not the Judge, has an "appearance of bias or unfairness" Robbins v. Sharp Healthcare, 71 Cal.Comp.Cases 1291, 1302. Due Process vis-à-vis language rights is mandatory. CCP 170.6. The Award is biased and unfair since it allows the Court to ignore that 1/3 of the history and exam by Dr. Chitnis was done with an inaccurate interpreter.

DR. CHITNIS' REPORTING CAN NOT SUPPORT AN AWARD BECAUSE POTENTIALLY SHE HAS NOT REVIEWED 2,898 PAGES OF MEDICAL RECORDS

Dr. Chitnis acknowledges receipt of 2,898 pages of records for which she requires an attestation to review. Joint 110, p. 30, lines 11

to 16. Dr. Chitnis further states she has no idea how many medical records she has received after the Applicant's surgery of 11/03/2020. Id. at p. 29, lines17 to 23. This suggests a gap in treatment records between the end of 2020 and the deposition of 03/27/2022. It is reasonable to assume Dr. Chitnis had not received any medicals for at least one year prior to her deposition. The PTCS was created around 04/07/2022. Only 11 days had passed from Dr. Chitnis deposition before Discovery was closed. Further development of the record is an issue identified in the Record. MOH, 08/23/2022, p.3.

Based on the arguments that the report of Dr. Chitnis is not substantial because it is inaccurate in at least 1/3 of its content and based on the argument that Dr. Chitnis likely did not review 2,898 pp. of medical records along with any significant amount of medical records between 11/03/2020 and 03/27/2022, there is no substantial evidence to support the WCJ's Award. LC 5903, 5952; Hamilton v. Lockheed Corporation (2001) 66 Cal.Comp.Cases, 473, 475-6 (Appeals Bd en banc) (Hamilton); see LC 5313. In fact, it is significant that Dr. Chitnis did not review a Lumbar MRI of 04/30/2021. Applicant 1. The MRI notes "postsurgical changes". Id. at p. 1. Dr. Chitnis has never received the MRI noting postsurgical changes. Dr. Chitnis' opinions lack the full medical record and can not support the Award. Garza v. Workmen's Comp.App.Bd. (1970) 33 Cal.Comp.Cases 500.

After a MVA that is claimed as industrial, the Applicant's doctors made a neurology referral to address Applicant's dizziness related to

the MVA. Applicant 4, p.3. Dr. Chitnis has also not seen this record. Dr. Chitnis does not have a history of this neurology referral. Dr. Chitnis' reporting is not substantial. Garza, supra. The Judge holds that the Applicant failed to prove the MVA as industrial. Opinion, p. 30. But at the same time, Dr. Chitnis never saw the referral to a neurologist for dizziness claimed by Applicant to be related to the MVA that occurred while Applicant was on his way to physical therapy. Opinion, pp. 19 – 20. The evidence that the Applicant had a 02/06/2019 MVA is unimpeached. See Opinion, p. 20. There is a prima facie claim to establish the MVA is a consequence of the medical care required for the accepted injury. It is unknown whether Dr. Chitnis explored aoe/coe of the MVA in her 12/01/2021 report because the interpreter Alicia Pagliere was inaccurate in her communications with the Applicant. AOE/COE of the MVA is unanswered through no fault of the Applicant.

Of significant concern is that Dr. Chitnis states under Past Medical History the Applicant has had no surgeries. Joint 109, p. 7. This is internally inconsistent with her knowledge of a surgery on 11/03/2020. Hegglin, supra. Equally concerning is that Dr. Chitnis identifies a MVA of around 2011, but never identifies the 02/06/2019 MVA among the Applicant's motor vehicle accidents. Joint 109, p. 8. The fact that Dr. Chitnis overlooks a known surgery in her history of surgery section and the fact that Dr. Chitnis overlooks a known MVA in her MVA history section suggest that either Alicia Pagliere failed to interpret accurately or that Dr. Chitnis did not proofread her

final report for inconsistencies. Dr. Chitnis reporting is based on incorrect history and guessing. Place v. Workers' Appeals Bd. (Place) (1970) 35 Cal.Comp.Cases 525.

WHILE DUE GREAT DEFERENCE, THE JUDGE'S CREDIBILITY OPINIONS ARE NOT PERSUASIVE

The Judge finds the "applicant testified credibly that he felt there were difficulties in the interpreting done by Alicia Pagliere." Opinion, p. 29. In this instance, the Judge found the Applicant credible. However, the Judge also found the Applicant was not credible based on comparing and contrasting testimony and evidence both before and after November 2021 when Dr. Chitnis last examined the Applicant. Opinion, p. 18 to 19. The Judge is owed great deference as to credibility. Garza v. Workmen's Comp. App. Bd. (1970) 35 Cal. Comp. Cases 500. But the Judge's recitation of testimony in the Opinion does not match the testimony in various MOH/SOE in this case.

The Judge carefully recites that the Applicant testified that "the numbness in his legs began after the last evaluation with Dr. Chitnis..." Opinion, p. 18. Further that the medical evidence showed Applicant had numbness in his legs before the last exam with Chitnis. Ibid. The Judge did not cite where the contradictory statements in the medical record were located. LC 5313. Filing this Reconsideration is not as meaningful had the Judge recited the specific evidence.

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The Applicant testified that the numbness in the legs started in 2021. SOE, 01/05/2023, P. 3. The summary of Applicant's testimony in the Judge's Opinion is entirely consistent with the SOE. Dr. Chitnis last exam was in November 2021. The Judge states the Applicant said his leg numbness started after November 2021. Opinion, p. 18. However, the Applicant clearly testified that "The numbness in his legs started in 2021" and not specifically after the Chitnis exam of November 2021. SOE, 01/05/2023, p. 3. The Applicant does not contradict himself in his testimony.

When the Applicant claims the leg numbness started in 2021, that would include from January thru October 2021. Those are 10 months in 2021 that were prior to Dr. Chitnis' exam in November 2021. The Judge's conclusion without more is not substantial. The conclusion is not able to support the Judge's finding of contradictory testimony/evidence on leg numbness. Garza, supra; Hamilton supra; Hegglin supra. LC 5313.

Interestingly, the Judge recited that the Applicant later said "his knee pain and numbness began after his last evaluation with Dr. Chitnis [November 2020]." But in the actual testimony of Applicant on 01/05/2023, the Applicant clearly testified that he had felt leg numbness since the date of the injury. SOE, 01/05/2023, p. 7. The knee is part of the leg. The Applicant also testified that he felt numbness specific to the tendons of both knees at the time of Dr. Chitnis' exam in November 2021. Id. at p. 8.

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The Applicant's unimpeached testimony is that he had knee numbness at the time of Dr. Chitnis' exam. The conclusion by the Judge that the Applicant has contradicted himself about his knee numbness is not based on actual Applicant testimony. The Applicant said he had knee numbness at the time of November 2021, but the Judge reports the Applicant said his knee numbness commenced after November 2021. The Judge misstated the Applicant's testimony in the Opinion. The Judge's summary of Applicant's testimony on 01/05/2023 is more reliable, is part of the record and is close in time to the actual testimony. The Opinion that the Applicant is mostly not credible is not supported by the actual summaries of testimony provided by the Judge.

The Judge next finds contradictory testimony regarding whether emotions became worse after the 11/03/2020 surgery. The Judge focuses exclusively on the symptoms of anxiety and depression. Opinion, p. 18. It is reasonable that emotions include anxiety and depression. But it is also reasonable that emotions include anger and fear. It is less than accurate for the Judge to determine there were no worse emotions reflected in the 2021 if the Judge only looked for anxiety and depression.

The Applicant testified to stress. SOE, 01/05/2023, p. 5. Stress is an emotion that the Judge did not look for in the 2021 evidence. The Applicant testified to feeling "irritated with gabapentin." Ibid. Irritation is an emotion. The Judge did not comment on whether he reviewed the 2021 medical reporting for irritation.

> What is unique about 1 of the 2 medical reports from 2021 is that one is an MRI report. Applicant 1. It is unlikely that a diagnosis of emotions would be present in a MRI. The second medical report states the Applicant feels the same in response to the question of how he was feeling. Applicant 4, p. 2. There is no point of comparison to explain same as what. The Judge can not assume that when the Applicant reported the same feelings that Applicant was not reporting worse emotions.

While Dr. Renor summarizes that the Applicant did not experience anxiety or depression, two things must be remembered. The report lists the presence of interpreter Donna Ezcurra, but her certification is nowhere to be found. Ibid. Second, The Applicant takes Cyclobenzaprine. Id at p. 3. Cyclobenzaprine, commonly known as Flexeril, is a prescription muscle relaxer that shares similar qualities with tricyclic antidepressants, which are used to treat depression, anxiety, and pain. Behavioral Health of the Palm Beaches, 7859 Lake Worth Road, Lake Worth, FL 33467, Website 08/09/2023. It is reasonable to assume the Cyclobenzaprine was relieving the Applicant's depression and anxiety. It is also reasonable that the Applicant might report no depression and no anxiety if his symptoms were relieved by the antidepressant, Cyclobenzaprine. In summary, the medical history and report are equally impacted by the fact that the interpreter's credentials are unknown and that the Cyclobenzaprine may have caused the Applicant to report no depression and no anxiety. The Award is not supported by the evidence and facts identified in the Opinion. LC 5313.

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RELIEF SOUGHT

Wherefore Applicant Attorney prays for: Granting of Petition for Reconsideration; Order allowing development of record per Tyler and McDuffie, especially including but not limited to a re-exam with Dr. Chitnis with 1 Spanish Certified interpreter that is not Alicia Pagliere.

Respectfully submitted,

Dated August 9, 2023

KENNETH D. MARTINSON
Kenneth Martinson San Bruno

VERIFICATION

I, Kenneth D. Martinson, declare that I have read the attached pleading and know its contents, which are true of my own knowledge, except as to those matters stated on my information and belief and which, I believe to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

08/09/2023

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TRANSMISSION VERIFICATION REPORT

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FAX : 4084092536
SER.# : BROJ9F127799

DATE,TIME	11/26 12:28
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MODE	STANDARD
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	ECM

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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION THREE

JUVENAL TORRES ZAMORA, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and MAYA RESTAURANT et al., Respondents.	A169128 (WCAB Case No. ADJ10586384)

BY THE COURT:*

The petition for writ of review is denied.

Dated: 01/24/2024

Tucher, P.J.
Presiding Justice

* Tucher, P.J., Fujisaki, J., and Petrou, J.

****

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Attorneys for Plaintiff

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

ASSOCIATION OF INDEPENDENT JUDICIAL INTERPRETERS OF CALIFORNIA, Plaintiff, v. ONE CALL CORPORATION dba ONE CALL, ONE CALL CARE MANAGEMENT, and/or ONE CALL CARE TRANSPORT & TRANSLATE; and DOES 1 through 25, inclusive, Defendants.	Case No. 24STCV02594 **COMPLAINT FOR VIOLATIONS OF BUS. & PROF. CODE §§17200 *et seq.***

PETITIONER ASSOCIATION OF INDEPENDENT JUDICIAL INTERPRETERS OF CALIFORNIA (hereafter "AIJIC" or "the Association"), on behalf of themselves and their members, hereby allege:

INTRODUCTION

This lawsuit is brought pursuant to California's Unfair Competition Law (hereafter "UCL"), Business & Professions Code sections17200 *et seq.*, to enjoin defendants from unlawful,

fraudulent, and unfair business practices and false advertising. ONE CALL CORPORATION dba ONE CALL, ONE CALL CARE MANAGEMENT, and/or ONE CALL CARE TRANSPORT & TRANSLATE (hereafter "ONE CALL") employs individuals and businesses that are impersonating certified court interpreters in California worker's compensation cases, resulting in harm to workers alleging industrial injuries who cannot proficiently speak or understand English, employers entitled to information on worker claims, insurance companies that must assess worker claims, courts that must hear worker claims, attorneys who are entitled to information on worker claims, and certified court interpreters.

PARTIES

1. Plaintiff AIJIC is a nonprofit organization registered with the California Secretary of State, with its principal office located in Studio City, Los Angeles County, California. The Association educates the legal community and agencies regarding current laws governing court interpreters, particularly Government Code sections 68560.5 and 68561, which require certified interpreters to be used for civil, criminal, or juvenile proceedings. In addition, the Association represents the interests of independent court interpreters before the Judicial Council of California and other state entities to ensure that independent interpreters have a voice in matters that directly affect their profession, among other things.

2. As a direct result of ONE CALL's violation of California law, Plaintiff has been required to expend resources to investigate and address defendants' unlawful, fraudulent, and unfair business practices. Defendants' actions frustrate AIJIC's mission and divert limited resources and time from other important organizational activities. AIJIC's losses include diverted directors' and officers' time and costs associated with AIJIC's representation in communicating with ONE CALL about the results of its investigation.

3. Defendant ONE CALL is a corporation registered with the Florida Secretary of State, with its principal office located in Jacksonville, California. ONE CALL provides care coordination services to the workers' compensation industry, which services include providing interpreters. Interpretation services are provided nationwide.

4. Plaintiff does not know the true names and capacities of the defendants named in this action as DOES 1-25, and therefore, sues them under fictitious names. Plaintiff will request

permission to amend this complaint or substitute the DOE defendants to state their true names and capacities when their identities are ascertained.

5. Plaintiff is informed and believes, and on that basis alleges, that at all times herein mentioned, each of the DOE defendants was the agent, servant, employee, and/or co-conspirator of ONE CALL, and, in doing the acts hereinafter alleged, was acting within the course and scope of their authority as such agent, servant, employee, and/or co-conspirator with the permission, knowledge, and consent of ONE CALL and their co-defendants and, further, that the defendants, and each of them, have authorized, ratified, and approved the acts of each of the other defendants with full knowledge of those acts.

JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction over the action pursuant to the California Constitution, Article VI, Section 10.

7. This Court has personal jurisdiction over the parties in this case. Plaintiff AIJIC maintains a presence in Los Angeles County, and by filing this Complaint, consents to this Court having personal jurisdiction over it. Defendants are authorized to, and in fact do, conduct business in California, including in Los Angeles County. Each has sufficient minimum contacts with California and have purposely availed themselves of the laws of California to market and engage in interpretation services in the State and Los Angeles County. Each has purposefully directed its conduct at California and availed itself of the benefits and protections of California law.

8. This case arises under California Business & Professions Code section 17203, which provides that any person who engages, has engaged, or proposes to engage in unfair competition may be enjoined in any court of competent jurisdiction. As more fully alleged in this Complaint, defendants' misrepresentations and omissions of material fact in employing individuals that impersonate certified interpreters constitute unfair competition in that such conduct involves false advertising, fraudulent business practices, unfair business practices, and unlawful business practices.

9. Venue is proper in this Court because Plaintiff resides in Los Angeles County, and a substantial part of the events or omissions which give rise to this lawsuit are connected to Los Angeles County.

STATUTORY FRAMEWORK

California's Unfair Competition Law

10. California's Unfair Competition Law (hereafter "UCL"), Business & Professions Code sections17200 *et seq.*, section 17200 prohibits businesses from engaging in unlawful, fraudulent, or unfair business practices. Section 17500 prohibits unfair, deceptive, untrue, or misleading advertising.

11. California Business & Professions Code section 17203 allows any person to pursue representative claims or relief on behalf of others if the claimant meets the standing requirements of California Business & Professions Code section 17204 and California Civil Procedure Code section 382.

12. Plaintiff has standing under California Business & Professions Code section 17204, which provides that actions for relief pursuant to the UCL shall be prosecuted exclusively in a court of competent jurisdiction by, *inter alia*, any person who has suffered injury in fact and has lost money or property as a result of the unfair competition.

13. Plaintiffs have standing under California Civil Procedure Code section 382, which provides that "when the question is one of a common or general interest, of many persons, of when the parties are numerous, and it is impracticable to bring them all before the court, one or more may sue or defend for the benefit of all."

14. For claims based on false advertising, Section 17535 of the UCL provides that any person, association, or organization which violates Section 17500 may be enjoined by any court of competent jurisdiction. Actions for such injunctive relief may be prosecuted by any person, association, or organization who has suffered injury in fact and has lost money or property as a result.

15. Section 17200 of the UCL prohibits "unlawful" business practices. An unlawful business practice is an act or practice, committed pursuant to business activity, that is at the same time forbidden by law. Virtually any law—federal, state, local or court-made—can serve as a predicate for an action under Section 17200. Defendants have engaged in unlawful business practices predicated on California Penal Code 529, Performance of Certain Acts in False

Character; negligence; negligent hiring, management, review, and oversight; and fraud upon the court.

16. Section 17200 of the UCL prohibits "unfair" business practices, which include unfair practices perpetrated by competitors which are harmful to other competitors and unfair practices perpetrated by a seller of services which are harmful to the consumer. Conduct is "unfair" within the meaning of Section 17200 if it is offensive to public policy, unscrupulous, oppressive, or substantially injurious to competitors or consumers.

17. Section 17200 of the UCL prohibits "fraudulent" business practices. This does not refer to the common law tort of fraud. Plaintiff need not prove that anyone was actually deceived, actually relied upon the fraudulent conduct, or actually sustained damage. Rather, Plaintiff need only show that members of the public are likely to be deceived. *See Wang v. Massey Chevrolet*, 97 Cal.App.4th 856, 871 (2002).

STATEMENT OF FACTS

18. ONE CALL advertises itself as having the nation's largest network of interpreters for worker's compensation depositions, medical appointments, and more.

19. ONE CALL has publicly disseminated untrue or misleading statements and advertising as regards the company's ability to provide certified interpreters for worker's compensation cases.

20. ONE CALL employs individuals and businesses that provide interpreter services for California worker's compensation cases.

21. On numerous occasions, individuals employed by defendants appeared in California worker's compensation cases, and these individuals have falsely impersonated certified California interpreters. Some of these individuals have falsely impersonated certified California interpreters in more than one instance.

22. The individuals employed by ONE CALL who falsely impersonated others were the agents, servants, employees, and/or co-conspirators of ONE CALL, and, in doing the acts herein alleged, were acting within the course and scope of their authority as such agents, servants, employees, and/or co-conspirators with the permission, knowledge, and consent of ONE CALL

and their co-defendants and, further, that the defendants, and each of them, have authorized, ratified, and approved the acts of each of the other defendants with full knowledge of those acts.

23. This appropriation of others' identities has benefited defendants commercially.

24. Some of the interpreters who were impersonated are members of AIJIC.

25. The individuals employed through ONE CALL and/or DOE defendants not only impersonated others, but these individuals also were not certified to interpret in California for worker's compensation proceedings.

26. In falsely impersonating certified California interpreters, members of the public, including injured workers, employers, attorneys, and others, were not only likely to be deceived but were actually deceived.

27. At all times, defendants were aware that those employed through ONE CALL and/or DOE defendants were impersonating others in their official capacity as certified interpreters.

28. On or about December 1, 2022, Plaintiff sent a letter to ONE CALL to inform it that California certified interpreters were being impersonated by unknown individuals employed through ONE CALL at Zoom depositions based in California. This letter, which was supported by sworn declarations from court reporters and impersonated interpreters, identified nine specific instances where impersonations had occurred in 2021 and 2022.

29. ONE CALL responded by stating it would no longer do business with the individuals or contractors who had provided interpreters for the Zoom depositions addressed in the December 1, 2022 letter. ONE CALL, however, refused to identify any of the individuals or contractors by name.

30. ONE CALL again employed one of the individuals previously involved in impersonating certified California interpreters. On this occasion, the individual appeared for a pre-deposition meeting with a worker and his attorney. On or about July 14, 2023, Plaintiff notified ONE CALL of this impersonation and asked that the impersonator's true name be provided. ONE CALL did not respond to Plaintiff's request.

31. Since July 14, 2023, individuals employed through ONE CALL and/or DOE defendants have continued to appear in California worker's compensation cases, and these

individuals have falsely impersonated others in their official capacity as certified California interpreters. In some instances, these individuals also have provided fake Judicial Council of California badges bearing the names of the certified court interpreters they were impersonating.

32. At all times, defendants failed to prevent the impersonation of California certified interpreters.

33. Defendants' actions have resulted in harm to injured workers who cannot proficiently speak or understand English. Without certified interpreters, the claims, benefits, and compensation that they may be entitled to has been jeopardized. The workers' fundamental right to due process and a fair hearing has been violated.

34. Defendants' actions have resulted in harm to those who rely upon certified interpreters in worker's compensation matters to evaluate worker claims, benefits, and compensations, including but not limited to medical evaluators, claims adjusters, attorneys, and the courts.

35. Defendants' actions have resulted in harm to certified interpreters in California who have been or may be impersonated by those employed by ONE CALL and/or DOE D=defendants. Defendants received a financial benefit at the expense of those who were impersonated.

36. Defendants' actions have resulted in harm to businesses that comply with California statutes and regulations mandating the use of certified court interpreters for worker's compensation proceedings.

FIRST CAUSE OF ACTION

(Violations of Bus. & Prof. Code, § 17200 *et seq.* – Unfair Competition Law)

37. Plaintiff incorporates by reference and re-alleges the preceding paragraphs.

38. Defendants have engaged in and continue to engage in business practices that constitute unfair competition as defined in California Business & Professions Code section 17200 *et seq.*

39. Defendants have violated and continue to violate the UCL through unlawful business acts and practices.

40. Defendants have violated and continue to violate the UCL through their unlawful business acts and practices in that these acts and practices violate California Penal Code section 529. California Penal Code section 529 is violated by "[e]very person who falsely personates another in either his or her private or official capacity, and in that assumed character does any of the following . . . Verifies, publishes, acknowledges, or proves, in the name of another person, any written instrument, with intent that the same may be recorded, delivered, or used as true. . . Does any other act whereby, if done by the person falsely personated, he might, in any event, become liable to any suit or prosecution, or to pay any sum of money, or to incur any charge, forfeiture, or penalty, or whereby any benefit might accrue to the party personating, or to any other person."

41. Defendants have violated and continue to violate the UCL through their unlawful business acts and practices in that these acts and practices violate California statutes and regulations governing certification in worker's compensation matters.

42. Defendants have violated and continue to violate the UCL through their unlawful business acts and practices in that these acts and practices are negligent. Specifically, defendants have negligently and carelessly failed to use reasonable care in providing interpreter services.

43. Defendants' business acts and practices further constitute negligent hiring, management, review, and oversight. Specifically, defendants have neglected to develop and/or enforce procedures to ensure the identity and certification of individuals employed through ONE CALL and/or DOE defendants.

44. Defendants have violated and continue to violate the UCL through their unlawful business acts and practices in that these acts and practices are a fraud upon the court. Specifically, individuals employed by ONE CALL and/or DOE defendants made material misrepresentations and have perjured themselves by impersonating certified California interpreters, and in some instances, providing fake Judicial Council of California badges bearing those certified court interpreters' names.

45. Defendants have violated and continue to violate the UCL through engaging in fraudulent business practices that are likely to deceive members of the public.

46. Defendants have violated and continue to violate the UCL through unfair business acts and practices. The impersonation of certified interpreters is harmful to ONE CALL's and

DOE defendants' competitors and to consumers of interpreter services. These impersonations are offensive to public policy, unscrupulous, oppressive, or substantially injurious to competitors or consumers.

47. Defendants have violated the UCL's provisions at Section 17500 *et seq.* regarding false advertising in that defendants have publicly disseminated untrue or misleading statements and advertising regarding the identity and qualifications of individuals employed through ONE CALL. Defendants knew, or in the exercise of reasonable care should have known, that these statements and advertising were untrue or misleading.

48. As a direct and proximate result of defendants' violation of the UCL, Plaintiff suffered injury in fact because they were forced to divert limited organizational resources away from their core mission and have incurred significant costs associated with investigating and communicating with ONE CALL.

49. As a direct and proximate result of defendants' violation of the UCL, important public interest rights have been harmed.

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REQUEST FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that the Court enter judgment in their favor and against defendants, as follows:

A. Declaring that ONE CALL, and all DOES hereafter identified and named, violated the UCL;

B. Ordering an accounting of all defendants for any and all profits derived by defendants from their business acts and practices in violation of the UCL;

C. Ordering an award of injunctive relief as permitted by law or equity, including enjoining ONE CALL, and all DOES hereafter identified and named, from continuing the acts or practices that are in violation of the UCL;

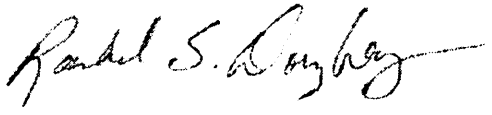
D. Ordering ONE CALL, and all DOES hereafter identified and named, to pay fees and litigation costs to Plaintiff pursuant to California Code of Civil Procedure section 1021.5 and the common-law private-attorney-general doctrine;

E. Ordering such other and further relief as is just and proper.

Dated: January 31, 2024

Respectfully submitted,

GREENFIRE LAW, PC



Rachel Doughty