CALIFORNIA MEDICAL-LEGAL QUALITY ASSURANCE CHECKLIST (For QMEs, AMEs, IMEs, & PTPs)

and

IMPORTANT TERMS AND CONCEPTS

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This document is intended to help medical practitioners provide consistent and accurate reports which will help facilitate the prompt provision of appropriate benefits to the injured worker.

Included are imbedded links (which are colored blue and underlined) to case law and also to definitions of important terms. The Table of Contents also has imbedded links to the associated topic.

We would like to thank the many individuals who assisted us over the last few years in improving this document. We want to especially thank Michelle Meyer, Director, Continuing Education, at the UC Berkeley School of Public Health Center for Occupational and Environmental Health (COEH) with whom we worked on the production of an Online, Asynchronous, On-Demand Module Medical-Legal report writing course. We take full responsibility though for the content and any errors in this document are ours.

Any comments related to this document may be sent to: QMEQuality@dir.ca.gov

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QUALITY ASSURANCE CHECKLIST

The following Quality Assurance Checklist is a template for medical-legal reports. It is a tool to help physicians in developing their report and is not a required format or template.

REPORT HEADER

Date: Enter the date of the report.

Report Recipients: List the names of report recipient(s) and their address / fax / email.

WORKER'S IDENTIFYING INFORMATION

RE: Date of birth

DOI: Date of Injury / Injuries

EMP: Name of Employer

Claim#: List Claim Number(s)

WCAB#: List WCAB Number(s)

DOE: List Date of Evaluation

REPORT INTRODUCTION

DEAR _____

- List report recipients as named in the Report Header.

ADVOCACY / COVER LETTERS

- Acknowledge and note the advocacy / cover letters from both applicant and defense representatives received (include date of letter and actual date received).
- Note if no letter(s) received.
- Suggest listing out here the specific questions presented by the parties to ensure that you address all issues presented for the evaluation (you do not need to include multi-page standardized or boilerplate requests / questions / paragraphs).

LOCATION OF EVALUATION

- List the location name and street address of the evaluation.

ATTESTATION: CA CODE OF REGULATIONS §35.5

- Provide attestation that you have fulfilled §35.5 (h) Disclosure Requirements.

§35.5 (h) Disclosure Requirements: Each reporting evaluator shall include in the report a declaration under penalty of perjury that the evaluator did not discriminate in any way

against the parties to the action or the injured worker in the evaluation process or in the content of the report.

ATTESTATION: CA CODE OF REGULATIONS §40

- Provide attestation that you have fulfilled §40 Disclosure Requirements.

§40. Disclosure Requirements: QME panel shall advise an injured worker prior to or at the time of the actual evaluation that he or she is entitled to ask the evaluator, and the evaluator shall promptly answer questions about any matter concerning the evaluation process in which the QME and the injured worker are involved and that the injured worker may discontinue the evaluation based on good cause.

EVALUATOR STATUS

Role Identification: I am serving in this case as a(n):

- Qualified Medical Evaluator (QME)
- Agreed Medical Evaluator (AME)
- Primary Treating Physician (PTP)
- Independent Medical Examiner (IME) Appointed by the WCAB Judge (Regular Physician = official term)
- Other (please clarify)

INDIVIDUALS WHO ASSISTED IN PREPARATION OF MEDICAL LEGAL REPORT OR EXAMINATION

- List person(s) (including qualifications and affiliation) who assisted (exclude interpreter or transcriber – see below) in the preparation of the medical-legal report or examination of the injured worker, including an Historian and/or Medical Records Summarizer.
- Include both the individual and their professional affiliation (company / organization) as applicable.

LIST OTHER INDIVIDUALS PRESENT DURING THE EVALUATION

- Family, friend, other(s).
- Use of an Interpreter – Modifier 93

Consider adding the below language to your report (include the interpreter's name, language interpreted, and certification #) to meet the Modifier 93 requirement for the use of an interpreter:

"This examination was conducted with the assistance of ***(Note language)*** interpreter ***(name of interpreter)***, certification number ***(Enter #)***. The use of an interpreter increased the amount of time needed to complete a comprehensive examination. The interpreter was present during the entire interaction including the history and physical examination. This report qualifies for a 10% augmentation pursuant to Title 8 California Code of Regulations 9795 modifier 93."

FACE-TO-FACE TIME WITH INJURED WORKER

- List face-to-face time. Actual time spent between the physician and the injured worker. CA Regulation 49-49.9

MLFS BILLING INFORMATION

- Include Medical Legal Fees Schedule (MLFS) code billing information and any modifiers
- e.g., ML 201, ML 202; possible modifiers 92, 93, 94, 95, 96, 97, 98.

ATTESTATION OF NUMBER OF PAGES OF RECORDS RECEIVED / REVIEWED

Physician attests to receiving Declaration(s) from the parties (include date records received) and states under penalty of perjury the number of pages received and billable page numbers.

When the received attestations are incorrect, here are several options to consider:

- **Option #1**: If the declaration(s) is incorrect and lists the wrong number of pages sent, contact the party who sent the records to get a corrected attestation/declaration before reviewing the records.
- **Option #2**: Note any discrepancy and explain the rationale (i.e., the deposition was condensed to 4 pages per page, etc.) for the actual number of pages billed.

MISSING RECORDS, ATTESTATIONS, OR DECLARATIONS:

- If no records were received or records were received without an attestation/declaration, note that the evaluation was performed without the benefit of records.
- Do not review the records without the declaration(s) as this is in violation of regulation section 9793(n).
- State whether there were missing records of potential importance.

RECORDS AND REPORT CONSIDERATIONS:

CA Regulation § 35(i) indicates the physician's course of action if the records have not been received 10 days after the date of the evaluation.

- If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report to comply with the statutory time frames under section 38 of Title 8 of the California Code of Regulations.
- The evaluator shall note in the report that the records were not received within the required time period.
- The following language for your Medical-Legal report is suggested if records were not received within 10 days following the evaluation:

Records were received but not reviewed. Per CA Code of Reg § 35(i) since the records were not received within 10 days after the evaluation, if you want me to review the records, please send a request for a supplemental report. (If records were received with no Declaration, add – Please also send the required Declaration which includes the number of pages of records sent.)

- State whether there were missing records of potential importance. The following language for your Medical-Legal report is suggested:

A summary of the records from one of the parties/attorneys or from a prior evaluating physician cannot be relied upon by the QME. A QME cannot comply with relevant portions of the Labor Code and the California Code of Regulations by reviewing only a summary of records in preparing the medical-legal report. Pursuant to the provisions of Labor Code § 4628(a)(2) and regulation § 41(c)(2), the physician must actually review all available records received as part of the medical-legal evaluation and/or the preparation of the medical-legal report.

INJURED WORKER IDENTIFYING INFORMATION

Worker Demographics

- Age
- Marital status
- Handedness
- Gender

Employment Information

- Name of the employer
- Employment start and end dates
- Job title

Current Work Status (include dates off work and return date to modified/full duty)

- Off Work
- Working Modified
- Working Full Duty

Job Duties / Description

- Include job duties / description, as described by the injured worker and any written job description received from employer, defense attorney or claims administrator.
- Note if there are any differences/discrepancies.

List and describe any concurrent or subsequent employment or subsequent employer(s) with dates and job duties.

HISTORY

HISTORY OF INJURY

- Describe injury as reported by the injured worker.
- If there is a discrepancy, contrast with advocacy letters and/or medical records.
- Remember, where discrepancies or differing descriptions of cause of injury exist, it is not the evaluator's duty to make a determination as to which one (ones) is (are) correct, but rather to report the possible outcomes subject to determination by the workers' compensation judge (WCJ).

LIST OF RECORDS / INFORMATION RECEIVED / REVIEWED

- Include dates of medical records including surveillance, depositions, test results, imaging studies, etc.

PERTINENT MEDICAL RECORDS SUMMARY

- Provide a written summary of pertinent medical records.

Recommendation: In addition to the specific industrial injury(ies) in question, include the history of relevant or pertinent pre-existing and subsequent industrial and nonindustrial injuries and illnesses.

Some evaluators like to integrate the patient's recollection contemporaneous to summarizing the medical records (and note any differences/disparities) while others choose to list the patient's recollected Medical/Psychiatric history separately.

CURRENT TREATMENT DETAILS

- Summarize the current treatment which is being provided to the injured worker including the names and specialties of medical providers.
- Summarize any future treatment that is recommended or planned by the treating physician(s).

PRESENT / CURRENT SYMPTOMS AND COMPLAINTS

Provide a summary documenting current symptoms and complaints.

INCLUDE THE FOLLOWING AS APPLICABLE:

- Specific body part(s) and overall complaints.
- This description should include radiation of symptoms with spatial characteristics, duration periodicity, and intensity / severity.
- Document the injured worker's pain by body part, including character and quality; provocative/aggravating, or palliative/alleviating factors.
- Describe any change(s) to other body systems such as bowel, bladder, and/or sexual functioning.
- Describe any change(s) to mental & emotional functioning, including changes in cognition/concentration, and/or emotional state (depression, anxiety, etc.).

- Document functional impacts, including interference with, or changes in, activities of daily living (ADLs) and work ability including the use of questionnaires.
- Describe the injured worker's daily routine (an average day in the life), including any change(s) from pre-injury, such as: exercise, outdoor activities, recreation, household chores, etc.

MEDICATIONS

Provide a list of current and past medications.

INCLUDE THE FOLLOWING AS APPLICABLE:

- Both prescription and over the counter medications, including vitamins, supplements, herbals, cannabis, etc.
- Dosage and number taken per day.
- Efficacy and any side effects of current and past medications.

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

Provide a written summary documenting the injured worker's review of systems, past medical history, including both industrial and nonindustrial.

ADDRESS THE FOLLOWING AS APPLICABLE:

- List allergies, whether medication-related or other.
- List diseases, illnesses, accidents, and injuries.
- List mental health conditions.
- List surgeries and hospitalizations.
- Document family history (medical conditions/illnesses, and also any alcoholism, substance abuse, major injuries, disability, chronic pain issues, etc.)
- Review of systems (constitutional, head and neck, cardiovascular, respiratory, genitourinary, gastrointestinal, neurological, psychiatric, and musculoskeletal).
- Focus on medical comorbidities (obesity, diabetes, smoking history, hypertension, adverse childhood experiences, mental health conditions, drug/alcohol/substance use/abuse) potentially impacting the work injury and resultant disability.

REVIEW OF PERSONAL HISTORY

- Social situation.
- Place of birth.
- Relevant childhood details:
  - Normal or dysfunctional - Note any history of adverse childhood experiences (ACE).
- List significant other(s) and children.

- Describe the living situation / arrangement (include details regarding accessibility).
- Describe the educational history/level (note if illiterate).
- List any military service and length of service, including active duty/combat tours.
  - Note any service-connected injuries or residual disability.
- Note recreational activities, both prior to the injury and currently.
- Note habits, including caffeine, alcohol, tobacco, and (recreational) marijuana.
- Note any illicit substance use, both currently and in the past.
- Note any legal history, including:
  - Past incarceration, past claims/lawsuits, pending claims/lawsuits.
- Note the injured worker's income. Include current source(s) of income, and previous source(s) of income. This may include family members, workers' compensation, pension, Long Term Disability, State disability, Social Security, etc.
- List the patient's work / occupational history.

PHYSICAL EXAMINATION

- Note that this examination was performed using AMA Guides 5th Edition protocols.

Address the following in your report summary, as applicable:

- Patient descriptors - e.g., was the patient pleasant and cooperative; a good or poor historian; etc.
- General observations - include information regarding appearance, constitution, and adaptive aids (braces, cane, wheelchair, etc.)
- Pain behavior and physical functioning, also note non-physiological findings.
- Vital signs
- Observations regarding the head, eyes, and ears.
- Observations regarding the mouth, throat, and nose.
- Observations regarding the neck.
- Observations regarding the cardiovascular system.
- Observations regarding the respiratory system and chest.
- Observations regarding the gastrointestinal system.
- Observations regarding the genitourinary system.
- Observations regarding the integumentary system (skin and subcutaneous tissue).
- Observations regarding the musculoskeletal system (ROM, atrophy/girths, deformity, joint laxity/stability, tenderness, alignment, leg length discrepancy, etc.).
- Summarize all provocative tests, including orthopedic and neurologic.
- List any neurological observations (including assessment of level of consciousness and mental status, thought processes and content, speech, and communication/language; cranial nerves; strength; sensation; sphincter

tone and superficial reflexes; deep tendon reflexes (DTR) including pathologic reflexes; coordination; gait & station).

IMPRESSION / DIAGNOSES

- List all relevant industrial diagnoses.
- Some evaluators list not only the claimed work-related injuries but also past and subsequent surgical procedures, test results, medical / psychiatric comorbidities, objective findings, etc.

DISCUSSION / SUMMARY

Provide a written discussion / case summary.

Your summary should include:

- In addition to the usual issues / questions raised, address any other specific (beyond the standard) questions raised by either party.
- Your opinions should meet the threshold of Substantial Medical Evidence.
- Explain the How and the Why of your conclusions.
- Describe if there were any inconsistencies in the record. Include how you resolved those inconsistencies to come to your determination, and why you came to that determination.
- Answer specific (non-standard) advocacy letter questions you listed in the beginning of your report.

PERMANENT AND STATIONARY OPINIONS (P&S)

Note: For any of the following, if your opinion differs from that of a referral source, a prior medical legal evaluator, or a treating physician, provide a detailed rationale for your opinion.

PERMANENT & STATIONARY

- **MMI / P&S**: List date(s) achieved.
- **TPD (Temporary Partial Disability)**: List date(s)
- **TTD (Temporarily Totally Disabled)**: List date(s)

Example: The injured worker has reached maximum medical improvement, and the condition is well-stabilized and unlikely to change substantially in the next year with or without medical treatment. Therefore, this injured worker is **permanent and stationary** and became so as of (**insert date**). Periods of temporary disability include time off work until P&S.

If P&S: Also fill out and submit — DWC AD Form 10133.36 (SJDB)

Physician's Return-to-Work & Voucher Report

Caveat: If the injured worker is not P&S/MMI, one or more of the concerned parties may ask for a current disability description and preliminary estimate of the whole person impairment (WPI) and apportionment as the parties may want to settle.

DISABILITY STATUS

- Provide a written summary documenting the injured worker's restrictions in activity of daily living limitations.

WORK STATUS

Explain your rationale for the opinion:

- Can work regular duty.
- Can work modified but not regular duty (within the disability restrictions listed above).

CAUSATION OF INJURY

Provide a written summary documenting findings on causation of injury.

- Remember, injury occurring in the course of employment (COE) is not a medical issue and is deferred to the trier of fact (WCAB Judge), whereas injury arising out of employment (AOE) is a physician decision (the physician provides direct evidence on whether and how the activities of work led to the current injury.)
- If medical records and the employee description differ, a review of a determination on AOE is based on the employee's history of injury, any medical evidence, and any other information (job description, video evidence, deposition testimony) that is provided. The physician must state their opinion and rationale for the determination.

APPORTIONMENT (Causation of Disability)

Identify all the contributing causal factors of the applicant's PD for every body part, system, or condition at issue. This requires an analysis of the industrial injury and all prior and subsequent industrial and non-industrial injuries as well as non-industrial contributing causal factors including pathology and preexisting conditions whether symptomatic or asymptomatic.

Your apportionment determination can and likely will be different from your causation determination.

FUTURE MEDICAL CARE NEEDS

Summarize any recommended future medical treatment.

- Title 8 Cal. Code of Regulations section 10682(b)(10) requires commentary on “Treatment indicated, including past, continuing and future medical care.”

- California workers' compensation law requires claims administrators to authorize and pay for medical care that is "reasonably required to cure or relieve" the effects of the injury.
  - This means care that follows **scientifically based medical treatment guidelines**.
- See DWC Physician Education
  - Qualified Medial Evaluators
  - Medical Treatment Utilization Schedule & MTUS Drug Formulary
  - Medical Legal Report Writing

In accordance with Labor Code sections 4061.5 and 4062 and title 8 CCR section 35.5(g)(2), an Agreed Medical Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue but shall provide an opinion about whether the injured worker will need future medical care to cure or relieve the effects of an industrial injury. Commenting on future medical care in terms of the MTUS is best practice while not required by statute nor regulation. Commenting on current medical treatment as being reasonable and necessary is appropriate.

AMA GUIDES IMPAIRMENT RATING

- Provide a standard **AMA Guides 5th Edition Impairment Rating**, with clear documentation of the process used to derive the rating.
  - Your written summary should include a statement that the most accurate impairment rating has been provided.
  - If the standard rating does not provide the most accurate impairment rating, provide an Almaraz Guzman Analysis (see below).
  - Explain why the standard approach is not the most accurate and why an alternative method within the four corners of the AMA Guides 5th Edition is more accurate.

ALMARAZ-GUZMAN ANALYSIS

Almaraz-Guzman (AG) Analysis (if applicable) to provide the most accurate impairment rating.

- Must stay within the four corners of the AMA Guides, 5th edition.
- Explain how and why the medical evidence supports your medical opinion.

ADDING VS COMBINING (CVC TABLE)

The CVC Table applies as a default in accordance with the 2005 Permanent Disability Rating Schedule and the AMA Guides in Chapter 1 on pages 9-10.

The CVC Table applies as a default in accordance with the 2005 Permanent Disability Rating Schedule and the AMA Guides in Chapter 1 on pages 9-10. On July 10, 2024, The Workers' Compensation Appeals Board issued an en banc (as to Sections I, II, and IV), Opinion and Decision After Reconsideration in Sammy Vigil v. County of Kern (2024) 89 Cal. Comp. Cases 686 (Appeals Board en banc decision).

- The Combined Values Chart (CVC) in the Permanent Disability Ratings Schedule (PDRS) may be rebutted and impairments may be added where an applicant establishes the impact of each impairment on the activities of daily living (ADLs) and that either:

  (a) there is no overlap between the effects on ADLs as between the body parts rated; or

  (b) there is overlap, but the overlap increases or amplifies the impact on the overlapping ADLs.

FINAL NOTATIONS

- I have provided the most accurate impairment rating.
- I have reviewed all the correspondence received and have addressed all issues.
- After careful consideration of all information available including any letters, medical records, the patient's given history and the physical examination and based on my education, training, and experience, this report and all of the opinions / conclusions within are based on a reasonable medical probability.
- The following is not mandatory but consider adding the following sentence given the lack of medical legal report feedback: *Please contact the undersigned if any action is taken indicating that this report fails to comply with standards of substantial medical evidence or requirement for reports pursuant to DWC regulations.*

DISCLAIMER

Under penalty of perjury, I declare the following to be true and correct:

- I certify that I have not discriminated against any party to this action or the injured worker in the evaluation process or in the content of this report.
- I certify this examiner reviewed the history and the past medical records directly with the patient. The examination of the patient, and interpretation of tests and x-rays, was all performed by this examiner. The dictation and the review of the final report were performed entirely by me. The opinions and conclusions contained in this report are entirely my own.

- I declare, under penalty of perjury, that the information contained in this report, and any attachment is true and correct, and that pursuant to Labor Code Section 4906(h), I have not violated Section 139.3. to the best of my knowledge and belief, except as information that I have indicated was received from others. As to that information, I declare under penalty of perjury that I have accurately detailed the information provided to me and, unless otherwise noted, I believe it to be true.

CLOSING IDENTIFIERS

- Physician's name.
- Date signed.
- City and County where signed.
- Signature of Physician.

AFTER COMPLETING YOUR REPORT

WHERE TO SEND REPORTS:

- Report Provision: Make sure to submit copies of the report to the appropriate parties. Include Proof of Service.
- §36. Service of Comprehensive Medical-Legal Evaluation Reports by Medical Evaluators Including Reports Under Labor Code Section 4061.
- §36.7. Electronic Service of Medical-Legal Reports by Medical Evaluators.

FOR A REPRESESENTED INJURED WORKER:

- Complete DWC Form 122 AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i)).

FOR AN UNREPRESENTED INJURED WORKER:

- Here is the link to the Disability Evaluation Unit (DEU) which must be served a copy of the report.

REQUIRED FORMS:

Go to Instructions for Panel QMEs to be used in Unrepresented Cases where you have found Permanent Impairment.

- DWC-AD 100 Employee's Permanent Disability Questionnaire.
  - Employee should bring to exam.
  - If not, print out and have injured worker fill out.
- DWC-AD 101 Request for Summary Rating Determination.
  - Sent with Medical Records from Claims Administrator.
  - Administrator.
- DWC-CA 10232.1 EAMS Cover Sheet
- DWC-CA 10232.2 EAMS Separator Sheets

- QME Form 111 Qualified Medical Evaluator's Findings Summary form (for unrepresented cases only)

FORMS FOR P&S STATUS ONLY:

- If P&S, fill out and submit DWC AD Form 10133.36 (SJDB) Physician's Return-to-Work & Voucher Report

FORMS FOR PSYCH EVALUATIONS ONLY:

- QME Form 120 Voluntary Directive for Alternate Service of Medical Legal Evaluation Report (if applicable)
- QME Form 121 Declaration Regarding Protection of Mental Health Record (if applicable)

IMPORTANT TERMS & CONCEPTS

Substantial Medical Evidence

The sequential analysis of what constitutes substantial medical evidence is best described in Part II.E. of the California Workers' Compensation Appeals Board (WCAB) en banc decision Escobedo v. Marshalls, 70 Cal. Comp. Cases 604, 620-621 (2005).

To be substantial evidence, expert medical opinion must be framed in terms of reasonable medical probability, be based on an accurate history and examination, and must set forth the reasoning used to support the expert conclusions reached. (Yeager Construction v. Workers' Comp. Appeals Bd.)

Substantial evidence can include medical records, lab tests, expert opinions, witness testimony, and other forms of proof that show an employee's injury was work related.

Physicians must explain **how** (what evidence) and **why** (the evidence or their medical opinion) they came to a given conclusion.

Substantial medical evidence means "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971).

1. In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability (>50% i.e., more likely than not).
2. A medical opinion is not substantial medical evidence if based on facts no longer germane, on incorrect legal theories, on inadequate medical histories or examinations, or on surmise, speculation, conjecture, or guess.
3. A medical report is not substantial medical evidence unless it sets forth the reasoning behind the physician's opinion, not merely his / her conclusions.

4. A medical opinion must be framed in terms of reasonable medical probability. It must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions.

Key elements of an expert's opinion that ensure that it rises to the level of substantial evidence:

1. Expert's testimony or opinion must involve matters beyond common experience.
2. Expert's opinion must be based on assumptions of fact supported by the evidence.
3. The assumptions of fact must be the type that are reasonably relied upon by other experts.
4. The controlling factors relied upon by the expert cannot be based on conjecture or speculation.
5. The expert must display a familiarity with the appropriate legal theory to be applied to the facts of the case.
6. The expert must relate the reasoning by which they progress from their material to their conclusion. This would be the how and why.

Causation of Industrial Injury

An industrial injury is defined as, "any injury or disease arising out of the employment" which causes any disability or need for medical treatment.

- **Specific Injury**: Occurs as a result of an incident or exposure which causes any disability or need for medical treatment.
- **Cumulative Injury**: Repetitive mental and/or physical traumatic activities that occur over time, with the combined effect causing any disability or need for medical treatment.

See Labor Code Section 3208 and Section 3208.1

The question of whether an injury is work-related or not is divided into two parts:

1. Did the injury "arise out of employment" (AOE)?
2. Did the injury "occur in the course of employment" (COE)?

Because the physician provides direct evidence on whether and how the activities of work led to the current injury, the physician answers the question of whether the injury arose out of employment (AOE).

The question of whether an injury occurred in the course of employment (COE) is not a medical question because it involves the circumstances of the accident or exposure.

If COE is in dispute, a workers' compensation judge will decide the issue based on evidence offered by the employee, the employer, or other witnesses and on legal precedents.

See Labor Code Section 3600

Liability: Liability for the injury "shall, without regard to negligence, exist against an employer for any injury sustained by his or her employees arising out of and in the course of employment and for the death of any employee if the injury proximately causes death," in those cases where the conditions of Labor Code 3600(a) are met.

Presumptions: There are presumptions for some injuries and employment (which are largely a legal issue). Presumption of injuries is in Labor Code Sections 3212 through 3213.2. There is also a presumption that the injury is accepted if the employer does not deny liability within a prescribed time period of receipt of the claim form. See Labor Codes Section 5401 and 5402.

Statutory Defenses: There are also statutory defenses to injuries. These defenses can be found in Labor Code section 3600.

Cumulative Trauma

For purposes of this document, CT refers to cumulative trauma, but other terminology includes:

- Cumulative trauma disorders (CTDs)
- Repetitive Stress Injury (RSI)
- Overuse syndrome
- Repetitive motion disorders

From a medical perspective, cumulative trauma disorders (CTDs) can affect many body systems including the spine, joints, muscles, tendons, ligaments, nerves, hearing, vision, cardiopulmonary, cancer from carcinogen exposure, vascular, psychiatric, and others.

Examples of cumulative trauma include:

- Musculoskeletal injuries as a result of repetitive motion, vibration, excessive force, awkward position, awkward postures, prolonged repetitive motions, productivity stress (pressure to perform), prolonged exposures, and tasks performed above the norm (for that individual).
- Industrial noise induced hearing loss is a cumulative trauma due to repetitive exposure to injurious noise levels.
- A psychiatric injury may be cumulative rather than due to a specific work event.

Labor Code Section 3208.1 states that an injury may be either:

- Specific: occurring as the result of one incident or exposure which causes disability or need for medical treatment; or
- Cumulative: occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. The date of a cumulative injury shall be the date determined under Labor Code Section 5412.

Labor Code Section 5412 determines the date of a CT injury for triggering the Statute of Limitations.

- "The date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment."

Labor Code Section 5500.5 determines the date of a CT injury for Carrier Liability Purposes.

- As stated above, Labor Code Section 5412 determines the date of the CT injury, which triggers the statute of limitations for the applicant. However, Labor Code Section 5500.5 provides a different formula for determining the date of a CT injury with regard to which employer is liable for the workers' compensation benefits.

Labor Code Section 5500.5 provides, in part, that liability:

- is "…limited to those employers who employed the employee…" during a period of one year "…immediately preceding either the date of injury, as determined pursuant to Section 5412," or
- "the last date on which the employee was employed in an occupation exposing him or her to the hazards of the occupational disease or cumulative injury," whichever occurs first.

The applicant may have two different dates of injury for the same CT claim.

Takeaway: There are two ways to fix the end date for that one-year window:

- The year leading up to the date of injury defined in Labor Code Section 5412 (knowledge plus disability), or
- The year leading up to the last date of employment with the injurious exposure.

Labor Code Section 5500.5 tells us directly: "whichever occurs first."

Labor Code Section 3208.1

- Explains that the date of injury for cumulative traumas (CT), which determines when the applicant's statute of limitation is triggered, is governed by Labor Code Section 5412
- That would be when the applicant has both disability plus knowledge that his or her disability is work-related

Labor code Section 5500.5

- Explains what the CT date of injury would be, with regard to determining carrier employer liability
- This is either the applicant's "last injurious exposure" or the date determined by Labor Code Section 5412, whichever date arrives first.

Causation of Psychiatric Industrial Injury

A psychiatric injury must be predominantly (51% or greater) caused by events of employment in order to be compensable. The exception for this is if the psychiatric injury resulted from the employee being a victim of a violent act or from direct exposure to a violent act. In those cases, events of employment only needs to be substantially (35-40% or greater) caused by these vents for the injury to be compensable.

A psychiatric injury is not considered compensable if:

- The psychiatric injury is caused 35% or more by good faith personnel actions.
- The claim is filed post-termination*
- The employee has been employed less than 6 months*
- The date of injury is on or after 1/1/2013 and the psychiatric injury is a derivate of a physical injury*

* There are exemptions to each of these preclusions that may apply detailed in the labor code. See Labor Code Section 3208.3 and Section 4660.1.

Permanent & Stationary (P&S) / Maximal Medical Improvement (MMI)

"Permanent and stationary status" is the point 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.

Permanent and stationary is a term used in workers' compensation interchangeably with maximum medical improvement.

In many cases, a future medical award will be included to cover ongoing treatment. There may be fluctuations in symptoms and potential flare-ups deserving increased medical attention.

§ 9785. Reporting Duties of the Primary Treating Physician

§10152. Disability, When Considered Permanent

Permanent Disability

The AMA Guides Fifth Edition (2000) defines permanent disability as a lasting impairment which alters an individual's capacity to meet personal, social, or occupational demands because of an impairment.

An impairment is defined as "A loss, loss of use, or derangement of any body part, organ system, or organ function."

The California Division of Workers' Compensation defines a permanent disability as any lasting disability that results in a reduced earning capacity after maximum medical improvement is reached.

It is important for physicians to recognize that the impairment rating derived through the use of the AMA Guides is only one component used to develop a permanent disability rating for injured workers.

The impairment rating is adjusted to account for the worker's diminished future earning capacity, occupation, and age at the time of injury to obtain the final permanent disability rating.

New & Further Disability

If the condition and disability worsen over time, within 5 years of the date of injury, the injured worker may file for New & Further Disability which would lead to reevaluation regarding the current disability and the impairment by the medical legal evaluator.

According to Labor Code Section 5410:

"Nothing in this chapter shall bar the right of any injured worker to institute proceedings for the collection of compensation within five years after the date of the injury upon the ground that the original injury has caused new and further disability."

Almaraz-Guzman (A-G) Analysis

Once an injured worker is deemed permanent stationary, the physician evaluator is tasked with providing the most accurate impairment rating.

First, a standard AMA Guides, 5th Edition rating is provided.

Secondly, if the standard rating is not the most accurate impairment, Almaraz-Guzman can be invoked with the following requirements:

1. Must provide the most accurate impairment rating.
2. Must stay within the four corners of the AMA Guides, 5th Edition.
3. Any Table, Chapter or Method can be used.
4. A-G is not to be used to achieve a desired result.
5. Opinion must be substantial medical evidence within a reasonable degree of medical probability – evaluator must explain with facts to support the A-G alternate rating.

6. Physician shall explain how (what evidence) and why (that evidence or their medical opinion) their determination is supported.

When conducting an Almaraz-Guzman (A-G) Analysis, the physician evaluator may consider various forms of substantial medical evidence to support the alternate rating. Here are some examples:

1. Diagnostic Tests: Results from diagnostic tests such as X-rays, MRIs, CT scans, or other imaging studies can provide objective evidence of the extent of the impairment and its impact on the injured worker's functionality.
2. Clinical Findings: The physician's own clinical observations and findings during physical examinations can be considered substantial medical evidence. These may include range of motion limitations, muscle strength assessments, sensory abnormalities, or other relevant clinical indicators.
3. Treatment Records: Detailed records of the injured worker's medical treatment and interventions can provide valuable information. This may include surgical reports, therapy notes, medication history, or any other documented treatment modalities that demonstrate the severity and progression of the impairment.
4. Medical Literature: Peer-reviewed medical literature can be referenced to support the alternate rating. The evaluator may cite relevant studies, research articles, or authoritative publications that demonstrate the correlation between specific impairments and their impact on functional abilities.
5. Expert Opinions: Consultations with other medical specialists or experts in the field can provide additional support for the alternate rating. Expert opinions should be based on their clinical expertise and knowledge in the specific area of impairment being evaluated.
6. Longitudinal Evidence: Evidence collected over time, including multiple evaluations, treatment progress reports, or documented changes in the injured worker's condition, can be used to establish the extent and progression of the impairment.
7. Functional Assessments: Functional assessments involve evaluating the injured worker's ability to perform specific tasks or activities related to their impairment. These assessments may include functional capacity evaluations, work simulation tests, or other standardized measures that objectively quantify the individual's functional limitations.
8. Medical Records: Comprehensive medical records, including progress notes, consultation reports, and relevant correspondence, can provide a holistic view of the injured worker's medical history and treatment trajectory. These records can help establish the severity, causation, and impact of the impairment.
9. Peer-Reviewed Guidelines: The physician evaluator may refer to established guidelines or consensus statements from reputable medical associations or expert panels. These guidelines often provide evidence-based recommendations for assessing impairments and can lend support to the alternate rating derived from the A-G Analysis.

10. Published Case Studies: Published case studies that describe similar cases or scenarios can be utilized to strengthen the medical evidence. These studies may present detailed information about the impairments, functional limitations, and outcomes, offering comparative evidence to support the alternate rating.
11. Patient Reported Outcomes (PRO): Patient-reported outcome measures, such as pain scales, disability questionnaires, or quality of life assessments, can provide valuable insights into the subjective experience of the injured worker. PRO data can supplement the objective medical evidence and contribute to a more comprehensive understanding of the impairment's impact.

It is important for the physician evaluator to ensure that the selected evidence is relevant, reliable, and directly supports the alternate rating derived from the A-G Analysis. The evaluator should clearly explain how the evidence relates to the impairment and why it justifies the proposed rating, providing a comprehensive and well-supported rationale for their determination.

It's important to note that the selection and utilization of substantial medical evidence will depend on the specific case, the nature of the impairment, and the available documentation. The physician evaluator should exercise professional judgment and ensure that the evidence chosen is relevant, reliable, and aligns with the guidelines outlined in the A-G Analysis.

When selecting and utilizing substantial medical evidence for the alternate rating derived from the Almaraz-Guzman (A-G) Analysis, there are several important considerations to keep in mind. These considerations help ensure that the evidence chosen is relevant, reliable, and appropriately supports the alternate rating. Here are some key factors to consider:

1. Relevance: The selected medical evidence should directly address the specific impairment being evaluated. It should demonstrate a clear connection between the impairment, its impact on functionality, and the alternate rating being proposed. The evidence should be specific to the injured worker's condition and align with the relevant provisions of the AMA Guides, 5th Edition.
2. Reliability: The medical evidence should be based on reliable sources and recognized standards of medical practice. It should come from reputable medical literature, peer-reviewed studies, expert opinions, or well-established guidelines. The evidence should be supported by scientific validity, methodological rigor, and consensus within the medical community.
3. Consistency: The selected evidence should be consistent with the overall medical documentation and clinical findings related to the injured worker's impairment. It should align with other medical records, diagnostic tests, treatment reports, or independent evaluations, if available. Consistency

across different forms of evidence strengthens the credibility and reliability of the alternate rating.

4. Objectivity: Whenever possible, the selected evidence should be objective and measurable. Objective evidence, such as diagnostic test results, imaging studies, or physical examination findings, carries more weight than subjective reports alone. However, subjective patient-reported outcomes and clinical observations can still be valuable as long as they are well-documented and supported by other objective measures.
5. Clinical Expertise: The physician evaluator's own clinical expertise and experience should guide the selection and interpretation of the medical evidence. Their professional judgment should be based on their knowledge of the medical field and familiarity with the specific impairment being assessed. Expertise in the relevant specialty areas can enhance the credibility of the alternate rating.
6. Transparency: The physician evaluator should be transparent in explaining how the selected medical evidence supports the alternate rating. They should clearly articulate the rationale behind their determination, highlighting the specific evidence used and its relevance to the impairment. The evaluator should provide a detailed explanation of the supporting facts, studies, or clinical observations that justify the alternate rating.

By carefully considering these factors, the physician evaluator can ensure that the substantial medical evidence chosen for the alternate rating is appropriate, reliable, and persuasive. This helps strengthen the validity of the A-G Analysis and promotes a more accurate assessment of the impairment.

Apportionment

Apportionment of permanent disability in California is all about parceling out all of the industrial and nonindustrial contributing-causal factors of the injured worker's permanent disability once the injured worker is at maximal medical improvement (MMI) / permanent and stationary (P&S).

Apportionment is based on the California Labor Code Sections 4663 and 4664.

When considering apportionment, the following are three critical portions or provisions of Labor Code Section 4663:

- Apportionment of permanent disability shall be based on causation (of permanent disability).
- A physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
- For a physician's report to be considered complete on the issue of permanent disability, the report shall include an apportionment determination. A physician shall make apportionment determination by finding:

- What approximate percentage of the permanent disability that was caused by the direct result of injury arising out of and occurring in the course of employment, and
- What approximate percentage of permanent disability was caused by other factors both before and after the industrial injury, including prior industrial injuries.

In Escobedo (2005) 70 CCC 604, the WCAB basically provided an analytical roadmap as to the construction and application of the apportionment statutes.

California Labor Code Section 4664 states that:

- The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.
- If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.
- The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662.
- Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100%.

A physician preparing a medico-legal report is tasked in part to determine apportionment of the disability arising from the specific and/or cumulative industrial injury(ies) in question but also prior or subsequent injuries or illnesses and nonindustrial contributing-causal factors that are the contributing cause of the disability.

- These nonindustrial contributing-causal factors may include asymptomatic conditions or underlying pathology that may or may not have been known or causing symptoms or disability prior to or at the time of the industrial injury.
- The key inquiry for the reporting physician is to determine whether any underling pathology or previously asymptomatic conditions are contributing-causal factor(s) of the applicant's current permanent disability.

In essence, the purpose of apportionment is to limit the employer's liability to the percentage of actual permanent disability caused by the current industrial injury(ies), not to determine what the level of permanent disability would have been absent the nonindustrial cause.

It is not enough to know the etiology or cause of a particular underlying pathology (congenital, developmental, heredity, etc.), or asymptomatic condition, but rather what approximate percentage the extent or severity of the pathology or disease process itself

(confirmed by diagnostic studies and supported by substantial evidence) is a present contributing-causal factor of the injured worker's permanent disability at the time of MMI status for each and every body part or condition at issue.

Apportionment to risk factors, rather than to evidence of actual cause, including to gender or age-based risk factors, is impermissible. It is also legally impermissible for a physician to apportion permanent disability based solely on age or gender.

Apportionment to causation of permanent disability based on conditions that are related to age, gender, genetics, or other personal characteristics may be appropriate if there is evidence of an actual medical condition that contributed to the disability. For example:

- Apportionment to age as a risk factor is not permissible, but apportionment to pre-existing arthritis, as evidenced in the medical records of the worker, is permissible, even though arthritis is an age-related condition.
- Apportionment to gender or menopause as a risk factor for industrial carpal tunnel syndrome is not permissible, but apportionment to actual pre-existing and/or non-industrial carpal tunnel syndrome, as established in the worker's own medical history, is permissible, even though carpal tunnel syndrome may be more common among post-menopausal women.

In these cases, apportionment to these pre-existing conditions, even if age or gender-related, is not discrimination; it is a medical determination as to the actual cause of the disability.

California Labor Code Section 4664 states that:

The physician is not to apportion to a condition or a risk factor (e.g., diabetes, degenerative disease, or a genetic condition) just because it exists, but only if the physician can articulate that the underlying condition or pathology is an actual contributing-causal factor of the applicant's permanent disability.

- How do we then decide to apportion in a way that is not speculative and meets the standard of substantial medical evidence?
- How do we decide with any particular injured worker that something else other than work is contributing to the disability?

The answer is that each physician must provide his or her best opinion based on reasonable medical probability and defend that opinion using substantial medical evidence.

Questions for every evaluating physician to consider:

- What is the nature of the injury?
- What are the person's job duties?
- What factors or activities outside of the work injury or exposure may be a contributing-causal factor of the resultant permanent disability at the time of the MMI evaluation?

- What prior or subsequent injuries has the applicant sustained, both on an industrial and nonindustrial basis?

Apportionment refers to parceling out all contributing-causal factors, both industrial and nonindustrial, of the resultant permanent disability:

1. What approximate percentage of the permanent disability was caused by the work injury or industrial exposure for each date of injury, and
2. What approximate percentage was caused by other nonindustrial contributing-causal factors.

Those contributing-causal factors, whatever they might be, may not have been known or even labor disabling previously, but if they are contributing-causal factors of the permanent disability, apportionment is required.

Your apportionment determination can and likely will be different from your causation determination.

APPORTIONMENT SUMMARY

Identify all the non-industrial contributing causal factors of the applicant's PD for every body part, system or condition at issue. This requires an analysis of all prior and subsequent industrial and non-industrial injuries as well as non-industrial contributing causal factors including pathology and preexisting conditions whether symptomatic or asymptomatic.

Key Points to Consider Regarding Substantial Medical Evidence

- Reasonable medical probability is the correct legal standard.
- Explain what is causing the disability and include how and why you came to the determination.
- Provide an approximation (use the word approximate) of the industrial and non-industrial percentages. Medical, mathematical, or scientific certainty is not required per LC 4663 and applicable case law.
- Note significance of diagnostic testing in the Escobedo "how and why" equation in terms of the severity factor of any non-industrial contributing causal factor.
- Provide a non-conclusory discussion required to meet the Escobedo "how and why" standard.
- Do not aggregate multiple non-industrial contributing causal factors of an applicant's permanent disability as it relates to each body part, system, or condition at issue.
- Do not adopt or incorporate the apportionment determination or opinion of a medical-legal evaluator in a different field.
- As is appropriate, discuss whether the current industrial injury aggravated, accelerated, or lit up an underlying preexisting pathology or disease process.
- Would the applicant's permanent disability be as large or great as it is in the absence of the non-industrial contributing causal factor or factors?

Combined Values Chart (CVC)

Address **Adding versus Combining** with the Combined Values Chart (CVC).

- The CVC Table applies as a default in accordance with the 2005 Permanent Disability Rating Schedule and the AMA Guides in Chapter 1 on pages 9-10.
- To opine otherwise, the physician must clearly explain/describe why the application of the CVC is not accurate and why adding impairment ratings is more accurate.

On July 10, 2024, The Workers' Compensation Appeals Board issued an en banc (as to Sections I, II, and IV), Opinion and Decision After Reconsideration in Sammy Vigil v. County of Kern. (2004) 89 Cal.Comp. Cases 686.

The Combined Values Chart (CVC) in the Permanent Disability Ratings Schedule (PDRS) may be rebutted and impairments may be added where an applicant establishes the impact of each impairment on the activities of daily living (ADLs) and that either:

a) there is no overlap between the effects on ADLs as between the body parts rated; or
b) there is overlap, but the overlap increases or amplifies the impact on the overlapping ADLs.

To meet the standard for (b), you must provide substantial medical evidence with a medically probable analysis/conclusion that the applicant would have significantly more limitations to support adding (this could be different body parts, or the same body part on each side, for example the hips). Your report should include an analysis as to how the ADLs have an effect on each body part and then you should explain why the disability and the two body parts together increase the impact on overall ADLs.

Accordingly, where an applicant seeks to rebut the CVC, they must establish the following: 1) The ADLs impacted by each impairment should be added, and 2) Either: a) The ADLs do not overlap, or b) The ADLs overlap in a way that increases or amplifies the impact on the overlapping ADLs.

DISCUSSION

The first method for rebuttal of the CVC is to show that the multiple impairments, in fact, have no overlap upon the effects of the ADLs. The WCAB believes that one significant point of confusion on the issue of overlap is that the analysis should focus on overlapping ADLs, not body parts. In determining whether the application of the CVC table has been rebutted in a case, an applicant must present evidence explaining what impact applicant’s impairments have had upon their ADLs. Where the medical evidence demonstrates that the impact upon the ADLs overlaps, without more, an applicant has not rebutted the CVC table. Where the medical evidence demonstrates that there is

effectively an absence of overlap on the ADLs, the CVC table is rebutted, and it need not be used, and the disability may be added instead of combined.

The second method for rebutting the CVC was first discussed in Kite, where applicant was awarded permanent disability by adding the impairment to each hip and not by combining the impairments as ordinarily required by the PDRS under the CVC. In Kite, the CVC was rebutted by substantial medical evidence showing the synergistic effect of the two impairments. 'Synergy' is the interaction of two or more disabilities so that their combined effect is greater than the sum of their individual effects or cooperative interaction among the disabilities that creates an enhanced combined effect.

The physician must explain that the amplified effect of the disability on the ADLs has resulted in an increase of impairment than what was anticipated by the AMA Guides. Thus, it is permissible to add impairments where a synergistic amplification of ADLs is shown. For example, if applicant had an impairment in the dominant hand, an evaluator might find that the impairment impacts the ADL of non-specialized hand activities, such as being able to button a shirt. If applicant's impairment was to both hands, one might expect the ability to button a shirt to be even more difficult. The purpose of the CVC, avoiding duplication, does not apply in such cases as the impairments are not duplicative, because the two impairments together are worse than having a single impairment.

Note: The WCAB stated that they cannot emphasize enough that to constitute substantial evidence a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions. The WCAB notes that the term 'synergy' is not a "magic word" that immediately rebuts the use of the CVC. Instead, a physician must set forth a reasoned analysis explaining how and why synergistic ADL overlap exists. If parties are searching for a magic word to use during a doctor's deposition, that word is "Why?". Rather than focusing on whether a specific term, including the term synergy, was used, it is imperative that parties focus on an analysis that applies critical thinking based on the principles articulated in Escobedo to support a conclusion based on the facts of the case. Such an analysis must include a detailed description of the impact of ADLs and how those ADLs interact.