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**CERTIFIED FOR PUBLICATION**

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SIXTH APPELLATE DISTRICT

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| MILPITAS UNIFIED SCHOOL DISTRICT,<br><br>Petitioner,<br><br>v.<br><br>WORKERS' COMPENSATION APPEALS BOARD and JOYCE GUZMAN,<br><br>Respondents. | H034853<br>(W.C.A.B. No.ADJ3341185)<br>(SJO 0254688) |

In this original proceeding the Milpitas Unified School 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 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 (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 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.

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

*Background*

Guzman worked for the District as a temporary employee beginning in October 2001 and as a permanent employee, a secretary/clerk, from September 2002 to May 2005. The District was permissibly self-insured for workers' compensation 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 flare-up 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 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]

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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.)

Guzman filed her first "Application for Adjudication of Claim" with the Workers' Compensation Appeals Board (WCAB) on February 9, 2004 (Case No. SJO 0244266), and a second application in August 2005 (SJO 0254688).[3] Steven D. Feinberg, M.D., the Agreed Medical Evaluator (AME), examined Guzman on April 11, 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.

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 percentage caused by the industrial injury/exposure is 100%."

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[3] Case No. 244266 is the number applicable to the date of injury, November 5, 2003. Case No. 254688 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.

On August 23, 2006, responding to a request for 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 re-analyze 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 re-examined Guzman and reported a total "whole person impairment"[5] of 14 percent, consisting of three percent on each upper extremity due to carpal tunnel syndrome, five percent impairment related to the lumbar spine, and five percent impairment related to the cervical spine injury.

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 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 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

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[5] "Whole person impairment, 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.)

be used and that the new AMA-based PDRS was applicable to the bilateral upper 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 SJO 244266, while the 2005 PDRS was applied in SJO 254688, 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 loss.[6] "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 Guides don't allow it."[7] 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

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[6] The DEU had received instructions to rate the injury to the upper extremities using that 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 rating.

[7] 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.

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 five percent for each upper extremity. Thus, relying on Dr. Feinberg's assignment of impairment based on the *Guides*, Wong rated Guzman's WPI as three 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 SJO 244266 and 12 percent in SJO 254688. The 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 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 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. 254688 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.[8] 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 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 ADLs in deriving an impairment rating. Thus, it was a "mistake" to believe that the AMA did not approve of Dr. Feinberg's method of assessing impairment based on functional loss of ADLs. The WCJ should have recognized that the application of clinical judgment to the AME's assessment of impairment and disability, including impairment of ADLs, 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 case with an ongoing dispute in *Almaraz v. Environmental Recovery Services* (*Almaraz*).[9]

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[8] Only Case No. 254688 was the subject of the petition for reconsideration or any of the ensuing proceedings.

[9] Mario Almaraz was a truck driver 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

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 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 4-3 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 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 component elements of the formula that resulted in the employee's scheduled rating." One of those components, the person's whole person impairment, could be challenged through the presentation of evidence that a different chapter, table, or method contained in the *Guides* more accurately describes the impairment. Whether in the initial

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did not fairly and accurately describe and measure the employee's impairment; in such cases, he argued, other measures of disability should be used.

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*

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; but see *Benson v. Workers' Compensation Appeals Bd.* (2009) 170 Cal.App.4th 1535, 1557 [both workers and employers were intended to benefit from Senate Bill No. 899].) The revised provisions substantially affected the assessment of an injured worker's permanent disability. A schedule for assessing permanent disability had been required 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." (§ 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.)

*2. Impairment and Disability*

The statutory revision most significant for the resolution of Guzman's case is the new condition that the determination of " '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).)

First 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, at 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."[10] (*Guides*, § 1.2, p. 4.)

A permanent disability, on the other hand, " ' "causes impairment of earning capacity, 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

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[10] Activities of daily living consist 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.)

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 the injured worker to a prescribed number of weeks of indemnity payments in accordance with that percentage. (§ 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.)

"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."[11] (§ 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."[12] (*Guides* § 1.2, p. 4, italics in the original.) In each case impairment ratings are

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[11] 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.)

[12] The authors explain the exclusion by pointing out that the "medical judgment 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)

combined and converted to a "whole person impairment" (WPI) rating,[13] which reflects the impact of the injury on the "overall ability to perform activities of daily living, excluding work."[14] (*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.[15] 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; see also *Vera v. Workers' Comp. Appeals Bd.* (2007) 154 Cal.App.4th 996, 1003; accord, *Tanimura & Antle v. Workers' Comp. Appeals Bd.* (2007) 157 Cal.App.4th 1489, 1494.)

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[13] 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.)

[14] Impairment of an upper extremity, for example, is converted to a WPI by multiplying the impairment rating by .6.

[15] 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).)

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 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 Compensation Appeals Bd.*(1968) 69 Cal.2d 436, 439; *Department of Rehabilitation v. Workers' Comp. Appeals Bd.* (2003) 30 Cal.4th 1281, 1290.)

In construing section 4660, the reviewing court must "ascertain the intent of the Legislature so as to effectuate the purpose 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.) "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. . . . ' "If possible, significance should 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.)

*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 whole person impairment. Relying primarily on 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 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.[16] Those parties join the District in arguing that the *Guides* must 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 SB 899 permanent disability costs have decreased and become "determinable, predictable, and quantifiable," an effect he believes will be lost with the current decision.

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. 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 by the patient. To "incorporate" is to "unite with or introduce into something already existent," to "take in or include as a

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[16] Amici 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 and the WCAB are the California Applicants' Attorneys Association and the California Society of Industrial Medicine and Surgery.

part or parts," or to "unite or combine so as to form one body." (Webster's Third New International Dict. p. 1145 (1993); Random House Dict. of the Eng. Lang. 2d ed. (1987) p. 968; American Heritage Dict. 3d ed., 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* as part of the basis for determining impairment.

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 p. 1-2)--is rebuttable (§ 4660, subd. (c)), and it would not comport with the legislative directive to construe 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 its supporting amici that this construction of section 4660, subdivision (b)(1), would defeat the legislative 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 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 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 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 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 function in performing activities of daily living."[17] (PDRS, pp. 1-4.)

Accordingly, while we agree with the District that the *Guides* should be applied "as intended" by its authors, such 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 from the balance of the Guides."

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[17] 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, pp. 1-5.)

The District and supporting amici 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 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 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 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 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, the Board 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.]" (*Yeager Const. v. Workers' Comp. Appeals Bd.* (2006) 145 Cal.App.4th 922, 928.)

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 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 Employers Direct insists that section 4660 permits incorporation of *only* the " 'descriptions and measurements of physical impairments and the corresponding percentages of impairments published in 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 physicians on the proper use of the *Guides* to evaluate impairment.[18] 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 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 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.

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[18] 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."

*5. Rebuttal of the PDRS*

The WCAB rested its decision in part on 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 be controverted and overcome." (*Universal City Studios, Inc. v. Workers' Comp. Appeals Bd.* (1979) 99 Cal.App.3d 647, 662-663.)

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."[19] (See *Frankfort General Ins. Co. v. Pillsbury* (1916) 173 Cal. 56, 58-60.) The Board noted pre-amendment decisions confirming the rebuttability of the Schedule. (See, e.g., *Glass v. Workers' Comp. Appeals Bd.* (1980) 105 Cal.App.3d 297, 307 [where schedule does not accurately reflect true disability, "it may be controverted and overcome"]; compare *Universal City Studios, Inc. v. Workers' 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].) "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 legislation, it must be presumed that the Legislature is aware of the judicial construction and approves of it."

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

(*Stavropoulos v. Superior Court* (2006) 141 Cal.App.4th 190, 196; *White v. Ultramar, Inc.* (1999) 21 Cal.4th 563, 572.)

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 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 Relations, and the California Chamber of Commerce interpret subdivision (c) of the statute to 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 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*.[20]

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."

At the same time, however, the WCAB majority 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.[21] 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

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

[21] 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.

alternative WPI rating. In order to support the case for rebuttal, 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. 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 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 WCAB has effectively created

new regulations," in violation of the Administrative Procedures Act. (Gov. Code §§ 11340, et. seq.)

We cannot reach the conclusion urged by the District because the premise of its 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 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 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.

ELIA, J.

WE CONCUR:

PREMO, Acting P. J.

DUFFY, J.

*Milpitas Unified School Dist. v. WCAB and Guzman*

H034853

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|---|---|
| Trial Court: | Workers Compensation Appeals Board |
| Attorneys for Petitioner: | Bradford & Barthel,<br>Donald R. Barthel and<br>Louis A. Larres |
| Attorneys for Amici Curiae<br>In support of Petitioner: | Finnegan, Marks, Theofel & Desmond and<br>Ellen Sims Langille, for the California<br>Chamber of Commerce;<br>David M. Skaggs, for Pacific Compensation<br>Insurance Company;<br>Vanessa L. Holton, Chief Counsel,<br>Steven A. McGinty, Asst. Chief Counsel,<br>Jesse N. Rosen, Staff Counsel, for<br>John C. Duncan, Director of Industrial Relations;<br>Saul Allweiss and<br>Michael A. Marks for California Workers'<br>Compensation Institute and American<br>Insurance Association;<br>Adam M. Cole, General Counsel,<br>Richard G. Krenz, Asst. Chief Counsel,<br>Christopher Citko, Senior Staff Counsel, for<br>Steve Poizner, California Insurance Commissioner |
| Attorneys for Respondent: | J. Bruce Sutherland and<br>Carla Spencer |
| Attorneys for Amici Curiae<br>In Support of Respondent: | Capurro, Rocha & Schmidt and<br>Joseph V. Capurro, for<br>California Applicants' Attorneys Association;<br>David Bryan Leonard for<br>California Society of Industrial Medicine<br>& Surgery, Inc. |

**CITY OF SACRAMENTO, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and ARTHUR CANNON, Respondents.**

**C072944**

**COURT OF APPEAL OF CALIFORNIA, THIRD APPELLATE DISTRICT**

***222 Cal. App. 4th 1360*; *167 Cal. Rptr. 3d 1*; *2013 Cal. App. LEXIS 1078*; *79 Cal. Comp. Cases 1***

**December 26, 2013, Opinion Filed**

**SUBSEQUENT HISTORY:** [***1]
The Publication Status of this Document has been Changed by the Court from Unpublished to Published January 15, 2014.

**PRIOR HISTORY:** W.C.A.B. No. ADJ7238353--WCJ Dominic E. Marcelli (FRE); WCAB Panel: Commissioners Sweeney, Brass, Lowe (dissenting) [see *Cannon v. City of Sacramento, 2012 Cal. Wrk. Comp. P.D. LEXIS 615* (Appeals Board panel decision)]

**DISPOSITION:** Petition for writ of review of a decision of the Workers' Compensation Appeals Board. Petition for writ of review *granted*, WCAB decision *affirmed*, and respondent to *recover* costs on appeal.

**CASE SUMMARY:**

**PROCEDURAL POSTURE:** Petitioner employer appealed a decision from respondent Workers' Compensation Appeals Board (California), which, after reconsideration, determined that respondent claimant was entitled to a permanent disability rating based on an agreed medical examiner's findings.

**OVERVIEW:** The claimant injured his left foot and heel while working. He was diagnosed with plantar fasciitis and received treatment. After his condition became permanent and stationary, no objective abnormalities were identifiable, but he continued to experience pain in his left heel that affected weight-bearing activities. An agreed medical examiner determined that the claimant's condition was equivalent to a limp with arthritis, which resulted in a seven percent whole person impairment for purposes of determining permanent disability. The court held that it was not improper to rate a claimant's condition by analogy where there were no objective findings and the rating was based solely upon a subjective experience of pain. Such a rating complied with the requirement of *Lab. Code, § 4660, subd. (b)(1)*, to incorporate the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) in determining the whole person impairment component of a scheduled permanent disability rating. The AMA Guides did not rate conditions with only subjective symptoms, instead calling for the physician's exercise of clinical judgment to assess the impairment most accurately.

**OUTCOME:** The court affirmed the board's opinion and decision after reconsideration.

**LexisNexis(R) Headnotes**

***Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities***
[HN1] See *Lab. Code, § 4660, subd. (a)*.

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

[HN2] The nature of the physical injury, as that phrase is used in *Lab. Code, § 4660, subd. (a)*, 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.

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

[HN3] The whole person impairment (WPI) component of any scheduled permanent disability rating must be based on the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition), i.e., the WPI component cannot be predicated on the opinion of a physician who has gone outside the four corners of the AMA Guides to make an impairment determination. Nevertheless, a physician is not inescapably locked into any specific paradigm for evaluating WPI under the Guides. *Lab. Code, § 4660, subd. (b)(1)*, provides that the WPI component of a scheduled rating is to be rooted in the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the AMA Guides. Therefore, *§ 4660, subd. (b)(1)*, does not mandate that the impairment for any particular condition must be assessed in any particular way under the Guides. Moreover, while the AMA Guides often set forth an analytical framework and methods for a physician in assessing WPI, the Guides do not relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment. Instead, the AMA Guides expressly contemplate that a physician will use his or her judgment, experience, training, and skill in assessing WPI.

***Workers' Compensation & SSDI > Administrative Proceedings > Evidence > Medical Evidence***

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

[HN4] Based upon the physician's judgment, experience, training, and skill each reporting physician (treater or medical-legal evaluator) should give an expert opinion on the injured employee's whole person impairment (WPI) using the chapter, table, or method of assessing impairment of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) that most accurately reflects the injured employee's impairment. This does not mean that a physician may arbitrarily assess an injured employee's impairment. As stated by the AMA Guides, a clear, accurate, and complete report is essential to support a rating of permanent impairment, and the report should explain its impairment conclusions. In other words, a physician's WPI opinion must constitute substantial evidence upon which the Workers' Compensation Appeals Board may properly rely, including setting forth the reasoning behind the assessment. A physician's WPI opinion that is not based on the AMA Guides does not constitute substantial evidence because it is inconsistent with the mandate of *Lab. Code, § 4660, subd. (b)(1)*.

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

[HN5] *Lab. Code, § 4660, subd. (b)(1)*, recognizes the variety and unpredictability of medical situations by requiring incorporation of the descriptions, measurements, and corresponding percentages in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th 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 a physician to include the descriptions, measurements, and percentages in the applicable chapter of the AMA Guides as part of the basis for determining impairment. The statutory mandate cannot be expanded by changing the word "incorporate" to "apply exclusively." Nor is it permissible to 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.

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

[HN6] There is nothing in *Lab. Code, § 4660*, as amended, that precludes a finding of impairment based on subjective complaints of pain where no objective abnormalities are found.

*Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities*
[HN7] See *Lab. Code, § 4660, subd. (b)(1).*

*Workers' Compensation & SSDI > Benefit Determinations > Permanent Partial Disabilities*
[HN8] The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) cannot rate syndromes that are poorly understood and are manifested only by subjective symptoms. To accommodate those complex or extraordinary cases, the AMA Guides call for the physician's exercise of clinical judgment to assess the impairment most accurately. Thus, the term "complex or extraordinary cases," as used in the case law, describes syndromes that are poorly understood and are manifested only by subjective symptoms, which the AMA Guides do not, and cannot, rate.

**SUMMARY:**

CALIFORNIA OFFICIAL REPORTS SUMMARY

The Workers' Compensation Appeals Board, after reconsideration, determined that a claimant was entitled to a permanent disability rating based on an agreed medical examiner's findings. The claimant injured his left foot and heel while working. He was diagnosed with plantar fasciitis and received treatment. After his condition became permanent and stationary, no objective abnormalities were identifiable, but he continued to experience pain in his left heel that affected weight-bearing activities. An agreed medical examiner determined that the claimant's condition was equivalent to a limp with arthritis, which resulted in a 7 percent whole person impairment for purposes of determining permanent disability.

The Court of Appeal affirmed, holding that it is not improper to rate a claimant's condition by analogy where there are no objective findings and the rating is based solely upon a subjective experience of pain. Such a rating complies with the requirement to incorporate the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th ed.) in determining the whole person impairment component of a scheduled permanent disability rating (*Lab. Code, § 4660, subd. (b)(1)*). The AMA Guides do not rate conditions with only subjective symptoms, instead calling for the physician's exercise of clinical judgment to assess the impairment most accurately. (Opinion by Robie, J., with Raye, P. J., and Nicholson, J., concurring.)

**HEADNOTES** [*1361]

CALIFORNIA OFFICIAL REPORTS HEADNOTES

**(1) Workers' Compensation § 107--Permanent Disability Rating--Nature of Physical Injury--Impairment.**--The "nature of the physical injury" in *Lab. Code, § 4660, subd. (a)*, 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.

**(2) Workers' Compensation § 107--Permanent Disability Rating--Impairment--American Medical Association's Guides--Incorporation--Use of Clinical Judgment.**--The whole person impairment (WPI) component of any scheduled permanent disability rating must be based on the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th ed.), i.e., the WPI component cannot be predicated on the opinion of a physician who has gone outside the four corners of the AMA Guides to make an impairment determination. Nevertheless, a physician is not inescapably locked into any specific paradigm for evaluating WPI under the Guides. *Lab. Code, § 4660, subd. (b)(1)*, provides that the WPI component of a scheduled rating is to be rooted in the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the AMA Guides. Therefore, *§ 4660, subd. (b)(1)*, does not mandate that the impairment for any particular condition must be assessed in any particular way under the Guides. Moreover, while the AMA Guides often set forth an analytical framework and methods for a physician in assessing WPI, the Guides do not relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment. Instead, the AMA Guides expressly contemplate that a physician will use his or her judgment, experience, training, and skill in assessing WPI.

**(3) Workers' Compensation § 107--Permanent Disability Rating--Impairment--American Medical Association's Guides--Incorporation.**--Based upon the physician's judgment, experience, training, and [*1362] skill each reporting physician (treater or medical-legal evaluator) should give an expert opinion on the injured employee's whole person impairment (WPI) using the

**have any accompanying objective measurement abnormalities, do not rate anything in the AMA Guides, whether or not these problems interfere with one's activities," that applicant's heel pain "interferes with weightbearing activities, particularly running," and that he "thought that by analogy, it would be similar to an individual with a limp and arthritis, resulting in the 7% impairment recommended" by agreed medical evaluator, that *Labor Code § 4660(b)(1)* does not mandate that impairment for any particular condition be assessed in any particular way under AMA *Guides*, and that statute provides merely that "the 'nature of the physical injury or disfigurement' shall *incorporate* [*emphasis by court of appeal*] the descriptions and measurements of physical impairments and the corresponding percentages of impairments."**

[See generally *Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 32.03A[1]*; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 2, 3, 6.]

**COUNSEL:** Laughlin, Falbo, Levy & Moresi, Sidney L. Lamb; Lenahan, Lee, Slater & Pearse and Gerald M. Lenahan for Petitioner. [*1364]

Mastagni, Holstedt, Amick, Miller & Johnsen, Jonathan W.A. Liff and Eric D. Ledger for Respondent Arthur Cannon.

No appearance for Respondent Workers' Compensation Appeals Board.

**JUDGES:** Opinion by Robie, J., with Raye, P. J., and Nicholson, J., concurring.

**OPINION BY:** Robie, J.

**OPINION**
[**2]

**ROBIE, J.**--In this workers' compensation case, an agreed medical examiner determined that respondent Arthur Cannon's left foot condition--plantar fasciitis--was equivalent to a limp with arthritis, which resulted in a 7 percent whole person impairment for purposes of determining permanent disability. On review, Cannon's self-insured employer, the City of Sacramento (the city), contends a rating of impairment by analogy to a different condition is impermissible when (as here) no objective abnormalities are found and the rating is based solely on subjective complaints of pain. The city also contends that a "rating [***2] by analogy" is permissible only in complex or extraordinary cases, and plantar fasciitis is neither.

Finding no merit in the city's arguments, we affirm.

FACTUAL AND PROCEDURAL BACKGROUND

In October 2008, Cannon injured his left foot and heel while working as a police officer for the city. He was diagnosed with plantar fasciitis and provided with physical therapy, cortisone injections, and an orthotic device. His primary treating physician found him permanent and stationary in January 2010, with no impairment of his activities of daily living and capable of performing his usual occupation.

In October 2010, an agreed medical examiner, Dr. William Ramsey, agreed Cannon was permanent and stationary and that there was no impairment but recommended that he be precluded from such things as prolonged running.

In February 2011, at the request of Cannon's attorney, Dr. Ramsey issued a supplemental report "to comment regarding [Cannon]'s impairment status using *Almaraz/Guzman-II* issues."[1] Dr. Ramsey explained that at the time of his original report in October 2010, he was "unable to offer any impairment [*1365] from a strict interpretation of the *AMA Guides, 5th Edition*"[2] because "other than some tenderness, [***3] no objective abnormalities were identifiable." Now, however, Dr. Ramsey determined that it was acceptable to characterize Cannon's residual condition "using a gait derangement abnormality" "by analogy, using *Almaraz/Guzman-II* as a basis." Noting that Cannon's problem was "relatively mild," with "the left heel causing weightbearing problems" and the likelihood that the condition "would ... be aggravated appreciably by running activity on other than a short-term basis," Dr. Ramsey recommended characterizing Cannon by reference to "Table 17-5, page 529," as having "a limp, despite the absence of any arthritic changes about adjacent [**3] joints, equivalent to 7% whole person impairment."

1 As we will explain, *Almaraz/Guzman* refers to the decision of the Workers' Compensation Appeals Board (the board) in *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School Dist. (2009) 74 Cal.Comp.Cases 1084.*

2 AMA Guides refers to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th ed.), discussed more fully below.

In June 2011, at the request of the city's attorney, Dr. Ramsey issued a second supplemental report "to further discuss the basis [***4] for [his] recommending some impairment due to [Cannon]'s residual heel complaints." In this report, Dr. Ramsey noted that "heel pain, or for that matter, other aspects of pain that do not have any

accompanying objective measurement abnormalities, do not rate anything in the *AMA Guides*, whether or not these problems interfere with one's activities. Thus, a strict interpretation of the Guides does not always appropriately characterize an injured worker's problems." Dr. Ramsey explained because Cannon's heel pain "interferes with weightbearing activities, particularly running," he "thought that by analogy, it would be similar to an individual with a limp and arthritis, resulting in the 7% impairment recommended."

The case was tried in October 2011. In a trial brief, the city argued that a rating by analogy under *Almaraz/Guzman* would be proper only if the case could be characterized as "complex or extraordinary," [***5] which Cannon's injury could not be. The workers' compensation judge (judge) agreed, finding that Cannon had no permanent disability because his medical condition was not complex or extraordinary and therefore did not warrant departure from a strict application of the AMA Guides.

Cannon petitioned for reconsideration, arguing that a case does not have to be complex or extraordinary to be rated by analogy under *Almaraz/Guzman*. The board granted reconsideration and, agreeing with Cannon, rescinded the judge's findings and award and returned the matter to him for a new permanent disability rating based on Dr. Ramsey's findings. With one member dissenting, the board explained that "the language cited by the [judge] to limit a rating by analogy only to cases with 'complex or extraordinary' [*1366] medication conditions does not support his interpretation. Rather than further restrict a physician's expertise, this language should be read to reflect the ability of a physician to rate an impairment by analogy, within the four corners of the Guides, where a strict application of the Guides does not accurately reflect the impairment being assessed." The board noted that Cannon's "condition, plantar fasciitis, [***6] does not have a standard rating, with no specifically applicable 'chapter, table or method' provided in the AMA Guides, and thus can only be rated by analogy to other impairments, and/or by analysis of the injury's impact on activities of daily living." The board concluded that Dr. Ramsey had "provided by analogy an accurate assessment of [Cannon]'s medical condition that meets the requirements of *Almaraz/Guzman*, for a condition that is not covered by the AMA Guides."

The city subsequently sought a writ of review, which we issued.

## DISCUSSION

On review, the city contends it is improper to rate an applicant's condition by analogy under *Almaraz/Guzman* where there are no objective findings and the rating is based solely upon subjective complaints and speculation. The city further argues that under the Sixth District's decision in *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd. (2010) 187 Cal.App.4th 808 [115 Cal.Rptr.3d 112]* (*Milpitas Unified*),"a variation from the strict application of the [AMA Guides'] whole person impairment analysis must apply only to those cases that are complex or extraordinary." We disagree on both points. [**4]

### I

*Statutory Background*

We draw the necessary statutory background, at some [***7] length, from *Milpitas Unified*:

"1. *[Labor Code] Section 4660*[3]

3 All further section references are to the Labor Code.

"The workers' compensation system in California underwent comprehensive reform in 2004 with the passage of Senate Bill No. 899. ... The revised provisions substantially affected the assessment of an injured worker's permanent disability. A schedule for assessing permanent disability had been required since 1937, and it was always expressly intended to manifest 'prima [*1367] facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.' [Citation.] ... [H]owever, 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.' [Citation.] As so directed, the administrative director published a new PDRS [(permanent disability rating schedule)] effective January 1, 2005, which incorporated the fifth edition of the [AMA] Guides in its entirety. [Citations.]

"2. *Impairment and Disability*

"The [***8] statutory revision most significant for the resolution of [this] case is the new condition that the determination of '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 [AMA Guides].' (*§ 4660, subd. (b)(1).*)

"First published in 1971 to provide 'a standardized, objective approach to evaluating medical impairments' [citation], 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. [Citation.] 'Impairment' is defined in the Guides as 'a loss, loss of use, or derangement of any body part, organ system or organ function.' [Citation.] The impairment ratings provided in the Guides 'were designed to reflect functional limitations and not disability.' [Citation.] 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.' [Citation.]

"A permanent disability, on the other hand, ' " 'causes impairment [***9] of earning capacity, impairment of the normal use of a member, or a competitive handicap in the open labor market.' " ' [Citation.] '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.' [Citation.] Permanent disability is expressed as a percentage: Anything less than 100 percent (total disability) entitles the injured worker to a prescribed number of weeks of indemnity payments in accordance with that percentage. [Citation.] [*1368] '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.' [Citation.]

[HN1] **(1)** " '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 [**5] employee, and his or her age at the time of the injury, consideration being given to an employee's diminished future earning capacity.' (*§ 4660, subd. (a).*) [HN2] The 'nature of the physical injury' refers to impairment, which is expressed as a percentage reflecting [***10] 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.' [Citation.] 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.' [Citation.] The WPI is then adjusted for diminished future earning capacity ... the employee's occupation classification at the time of the injury, and age. 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." (*Milpitas Unified, supra, 187 Cal.App.4th at pp. 818-820*, fns. omitted.)

II

*Almaraz/Guzman*

**(2)** In *Almaraz/Guzman*, the board concluded that [HN3] "the WPI component of any scheduled permanent disability rating *must* be based on the AMA Guides, i.e., the WPI component cannot be predicated on the opinion of a physician who has gone outside the four corners of the Guides to make an impairment determination." (*Almaraz/Guzman, supra, 74 Cal.Comp.Cases at p. 1101.*) The board then went on to explain [***11] as follows:

"Nevertheless, although the WPI component of a scheduled rating must be founded on the AMA Guides (except in the case of psychiatric impairments), a physician is not inescapably locked into any specific paradigm for evaluating WPI under the Guides. *Section 4660(b)(1)* provides that the WPI component of a scheduled rating is to be rooted in 'the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the [AMA Guides].' Therefore, *section 4660(b)(1)* does not mandate that the impairment for any particular condition must be assessed in any particular way under the Guides. Moreover, while the AMA [*1369] Guides often sets forth an analytical framework and methods for a physician in assessing WPI, the Guides does not relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning 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.

"Specifically, the AMA Guides provides: 'The physician's [***12] role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function, and identify abilities and limitations to performing activities of daily living. ... Performing an impairment evaluation requires considerable medical expertise and judgment.' [Citation.] Similarly, the Guides states: '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 [**6] the modification in writing.' [Citation.] Further, the Guides recites: 'In situations where impairment ratings are not provided, the *Guides* suggests that physicians use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measureable impairment resulting from similar conditions with similar impairment of

function in performing [***13] activities of daily living. [¶] 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.' [Citation.]

(3) "Therefore, [HN4] based upon the physician's judgment, experience, training, and skill each reporting physician (treater or medical-legal evaluator) should give an expert opinion on the injured employee's WPI using the chapter, table, or method of assessing impairment of the AMA Guides that most accurately reflects the injured employee's impairment. [Citation.] This does not mean, of course, that a physician may arbitrarily assess an injured employee's impairment. As stated by the AMA Guides, '[a] clear, accurate, and complete report is essential to support a rating of permanent impairment' and the report should 'explain' its impairment conclusions. [Citation.] In other words, a physician's WPI opinion must constitute substantial evidence upon which the [board] may properly rely, including setting forth the reasoning behind the assessment. [Citation.]

"A physician's WPI opinion that is not based on the [***14] AMA Guides does not constitute substantial evidence because it is inconsistent with the mandate of [*1370] *section 4660(b)(1)*." (*Almaraz/Guzman, supra, 74 Cal.Comp.Cases at pp. 1103-1104*, fn. omitted.)

III

*Milpitas Unified*

In *Milpitas Unified*, the Sixth District reviewed the board's decision in *Almaraz/Guzman* upon petition by Guzman's employer. (*Milpitas Unified, supra, 187 Cal.App.4th at p. 812.*) The court framed the "primary issue" as "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." (*Id. at p. 820.*) In addressing that issue, the court "agree[d] with the District that the Guides must be applied 'as intended' and 'as written,' " but the court took "a broader view of both [the AMA Guides'] text and the statutory mandate." (*Id. at p. 822.*) The court explained as follows:

[HN5] **(4)** "*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, [***15] 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.' [Citation.] *Section 4660, subdivision (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.

"We cannot expand the statutory mandate by changing the word 'incorporate' to 'apply exclusively.' Nor can we read into [**7] 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 [***16] to those criteria for every condition. A narrower interpretation would be inconsistent with the clear provision that the Schedule--which itself incorporates the Guides [citation]--is rebuttable (*§ 4660, subd. (c)*), and it would not comport with the legislative directive to construe the workers' compensation statutes [*1371] liberally 'with the purpose of extending their benefits for the protection of persons injured in the course of their employment.' ..." (*Milpitas Unified, supra, 187 Cal.App.4th at p. 822*, citations omitted.)

The court later added as follows: "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. [Citation.] The Guides ratings 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. [Citation.] The Guides also cannot rate syndromes that are 'poorly understood and [***17] are manifested only by subjective symptoms.' [Citation.] [¶] To accommodate 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." (*Milpitas Unified, supra, 187 Cal.App.4th at p. 823.*)

IV

*The City's Arguments*

The city first argues that the legislative intent behind Senate Bill No. 899 (2003-2004 Reg. Sess.) in 2004 was "to promote consistency and uniformity based upon objective findings" and here "there is consistency in the objective findings and that is there are no objective findings." The thrust of the city's argument is that a rating by analogy under *Almaraz/Guzman* is not permissible where (as here) no objective abnormalities are found and the rating is based solely on subjective complaints of pain.

**(5)** The city's argument is not persuasive. [HN6] There is nothing in the 2004 amendment to *section 4660* that precludes a finding of impairment based on subjective complaints of pain where no objective abnormalities are found. If [***18] the 2004 amendment had required *strict compliance* with or the *mechanical application* of the AMA Guides in assessing impairment, then the city might have a valid point because, as Dr. Ramsey explained here, "aspects of pain that do not have any accompanying objective measurement abnormalities, do not rate anything in the *AMA Guides*, whether or not these problems interfere with one's activities." Thus, under a strict application of the AMA Guides, a condition that has no objective manifestation cannot be considered an impairment. As the Sixth District found in *Milpitas Unified*, however, [**8] if the [*1372] Legislature had intended to require such an approach to the determination of permanent disability, "it would have used different terminology to compel strict adherence to th[e] criteria [in the AMA Guides] for every condition." (*Milpitas Unified, supra, 187 Cal.App.4th at p. 822.*) Instead, the Legislature provided only that [HN7] "the 'nature of the physical injury or disfigurement' shall *incorporate* the descriptions and measurements of physical impairments and the corresponding percentages of impairments ... ." (*§ 4660, subd. (b)(1)*, italics added.) Here, Dr. Ramsey complied with this legislative directive [***19] by rating Cannon's condition by analogy to the part of the AMA Guides dealing with a limp and arthritis. The city's argument that he was not allowed to do so because Cannon's condition had no objective manifestation is without merit.

The city's second argument is that under *Milpitas Unified*, a rating by analogy under *Almaraz/Guzman* is permissible only in complex or extraordinary cases. The city asserts, ipse dixit, that "[p]lantar [f]asciitis is neither complex nor extraordinary" and therefore a rating by analogy was improper here.

**(6)** We agree with the board majority that this is an unwarranted interpretation of the Sixth District's decision in *Milpitas Unified*. What the Sixth District said was this: [HN8] "The Guides ... cannot rate syndromes that are 'poorly understood and *are manifested only by subjective symptoms*.' [Citation.] [¶] To accommodate *those complex or extraordinary cases*, the Guides calls for the physician's exercise of clinical judgment to assess the impairment most accurately." (*Milpitas Unified, supra, 187 Cal.App.4th at p. 823*, italics added.) Thus, the Sixth District was using the term "complex or extraordinary cases" to describe "syndromes that are 'poorly understood and [***20] are manifested only by subjective symptoms,'" which the AMA Guides do not, and cannot, rate.

**(7)** It is undisputed that Cannon's condition--plantar fasciitis--is manifested only by his subjective experience of pain. Thus, his condition appears to fall right into the category of cases the Sixth District was describing in *Milpitas Unified*, where the AMA Guides "calls for the physician's exercise of clinical judgment to assess the impairment most accurately." (*Milpitas Unified, supra, 187 Cal.App.4th at p. 823.*) Dr. Ramsey performed that assessment here and determined that Cannon's plantar fasciitis resulted in a 7 percent whole person impairment equivalent to a limp with arthritis. The city has shown no error in that assessment and no error in the board's decision based on that assessment. [*1373]

DISPOSITION

The board's opinion and decision after reconsideration is affirmed. Respondents shall recover their costs on review in this court. (*Cal. Rules of Court, rule 8.493(a)*.)

Raye, P. J., and Nicholson, J., concurred.

Buhrer has workers' compensation liability (as distinguished from tort liability) under the governing statutes and cases (see, e.g., §§ 3351, subd. (d), 3352, subd. (h); *Zaragoza v. Ibarra* (2009) 174 Cal. App. 4th 1012, 1016 [95 Cal. Rptr. 3d 264]; *Cedillo v. Workers' Comp. Appeals Bd.* (2003) 106 Cal. App. 4th 227, 232-235 [130 Cal. Rptr. 2d 581, 68 Cal. Comp. Cases 140]), and if so, whether Buhrer has homeowner's insurance, which by law must include workers' compensation coverage (Ins. Code, §§ 11590, 11591).[6] We express no opinion as to these issues, or as to whether Buhrer would be subject to tort liability in the absence of such insurance.[7] (See *Cortez v. Abich* (2011) 51 Cal. 4th 285, 291, 298 [120 Cal. Rptr. 3d 520, 246 P.3d 603, 76 Cal. Comp. Cases 81]; *Ramirez v. Nelson* (2008) 44 Cal. 4th 908, 913 [80 Cal. Rptr. 3d 728, 188 P.3d 659].)

## III. Disposition

The summary judgment is reversed and the case remanded for further proceedings consistent with this opinion.[8] Respondents to recover costs on appeal.

Banke, J.

We concur:

Marchiano, P.J.

Margulies, J.

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[6] At oral argument, counsel for Buhrer advised these issues are pending in a related workers' compensation case.

[7] Further dispositive motions may be appropriate upon a more developed record, including with respect to the workers' compensation claim Mathies has filed against Buhrer.

[8] The request for judicial notice filed May 16, 2012, is denied as to Exhibit Nos. 1 and 2 and granted as to Exhibit No. 3.



## DIGESTS OF WCAB DECISIONS DENIED JUDICIAL REVIEW

Athens Administrators, administrator for East Bay Municipal Utility District, Petitioner v. Workers' Compensation Appeals Board, **Richard Kite**, Respondents

Civil No. A137618—Court of Appeal, First Appellate District, Division Three

78 Cal. Comp. Cases 213, 2013 Cal. Wrk. Comp. LEXIS 34

February 28, 2013 Writ of Review Denied

*Prior History:* W.C.A.B. No. ADJ6719136—WCJ Christopher Miller (OAK); WCAB Panel: Commissioner Brass, Chairwoman Caplane, Commissioner Moresi [*see* Kite v. EDMUD, 2012 Cal. Wrk. Comp. P.D. LEXIS 640 (Appeals Board panel decision)]

*Disposition:* Petition for writ of review denied

*Counsel:* For petitioner—Finnegan, Marks, Theofel & Desmond, by Sean J. Desmond
For respondent employee—Boxer & Gerson, by Michael G. Gerson

**Permanent Disability—Rating—AMA *Guides*—WCAB held that WCJ did not err in combining permanent disability stemming from injury to each of applicant/forklift operator's hips by using simple addition, rather than by using combined values chart or reduction method, based on panel qualified medical evaluator's opinion, when WCAB found that, although 2005 Permanent Disability Rating Schedule provides that impairments are *generally* combined by using reduction formula, AMA *Guides* describe several methods of combining impairments, that rigid application of multiple disabilities table**

**is not mandated, that scheduled impairment rating is rebuttable, and that panel qualified medical evaluator appropriately determined that impairment resulting from applicant's left and right hip injuries was most accurately combined by using simple addition rather than by using combined values formula.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 32.03A; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 3, 4.]

**Permanent Disability—Offers of Regular, Modified, or Alternative Employment—WCAB upheld WCJ's finding that applicant was entitled to 15 percent increase in permanent disability awarded for hip injury, based on defendant's failure to send return-to-work offer until well beyond 60 days from permanent and stationary date, and that applicant's return to work prior to his permanent and stationary date did not preclude increase in permanent disability award pursuant to decision in *City of Sebastopol v. W.C.A.B.* (*Braga*) (2012) 208 Cal. App. 4th 1197, 146 Cal. Rptr. 3d 713, 77 Cal. Comp. Cases 783, when applicant suffered two periods of temporary disability following hip surgery, unlike employee in *Braga* who missed no time from work, and when defendant had not yet paid permanent disability.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 7.02[4][d][iii], 32.04[2].]

Applicant, while working as a forklift driver for Defendant EBMUD, suffered an admitted cumulative injury to his bilateral hips ending on 8/14/2007. He was taken off work to undergo a right hip replacement, but returned to work approximately three months later and worked until 8/30/2009, at which time he underwent left hip replacement. Applicant returned to work on 12/14/2009, following the second hip replacement.

Panel QME Dr. Ernest Cheng issued a report in which he concluded that Applicant's job duties contributed to the osteoarthritis in his hips, that Applicant's hip condition in both hips was P&S, and that Applicant had 20 percent WPI with respect to each hip under the AMA *Guides* or 40 percent PD considering both hips. With regard to his finding of impairment, Dr. Cheng explained that, in his opinion, the best way to combine Applicant's impairments to the right and left hips would be to add together them as opposed to using the Combined Values Chart, which would result in a lower WPI.

On 12/17/2010, Defendant mailed Applicant a Notice of Offer of Regular Work. Defendant paid no PD indemnity.

The matter proceeded to a trial on the primary issues of the extent of Applicant's PD and whether Defendant's tardy return-to-work offer entitled Applicant to a 15 percent increase in PD pursuant to Labor Code § 4658(d)(2). The WCJ issued an F&A awarding Applicant 46 percent PD, based on the opinion of Dr. Cheng that "there is a synergistic effect of the injury to the same body parts bilaterally versus body parts from different regions" and that adding the impairments for both hips produced the most accurate reflection of Applicant's actual PD. The WCJ also awarded the statutory 15 percent increase in PD, based on



Defendant's failure to send the return-to-work offer until well beyond 60 days after Applicant became P&S.

Defendant filed a Petition for Reconsideration, contending in substance that the WCJ erred by combining the PD stemming from each hip, using simple addition rather than by utilizing the Combined Values Chart or reduction formula set forth in the 2005 Permanent Disability Rating Schedule, and that Applicant was not entitled to an increase in his PD indemnity rate pursuant to Labor Code § 4658(d)(2). With respect to the latter contention, Defendant acknowledged that it did not provide Applicant with a return-to-work offer in a timely manner but maintained that there was no basis to award increased compensation because, by the time Applicant's condition had become P&S so as to trigger Defendant's duty to offer work, Applicant had already returned to work.

The WCJ recommended that reconsideration be denied. In his report, the WCJ opined that Defendant, in contending that it was improper to "combine" Applicant's hip impairment simply by adding the impairment ratings for each hip, too narrowly interpreted the term "combine" as it applies to determining PD when multiple body parts are involved. Noting the lack of support for Defendant's contention, the WCJ explained in relevant part:

> . . . [N]owhere in the Labor Code, the rating schedule or the AMA Guides is "combine" defined as entailing [the reduction] method, or any particular method. The schedule provides that impairments are *generally* combined using the [reduction] formula. The Guides, upon which the schedule is based, describe several methods of combining impairments, . . . belying the narrow interpretation of "combine" urged here by defendant. [*Emphasis by WCJ*]

While observing that there are several different methods that may be employed to combine multiple impairments, the WCJ found the following language in the AMA *Guides* instructive with respect to determining the most appropriate method in a particular case:

> A scientific formula has not been established to indicate the best way to combine multiple impairments. Given the diversity of impairments and great variability inherent in combining multiple impairments, it is difficult to establish a formula that accounts for all situations. A combination of some impairments could decrease overall functioning more than suggested by just adding the impairment ratings for the separate impairments (e.g., blindness and inability to use both hands). When other multiple impairments are combined, a less than additive approach may be more appropriate. States also use different techniques when combining impairments. Many workers' compensation statutes contain provisions that combine impairments to produce a summary rating that is more than additive. Other options are to combine (add, subtract, or multiply) multiple impairments based upon the extent to which they affect an individual's ability to perform activities of daily living.

Although the 2005 Schedule provides that impairments and disability are generally combined using the reduction formula, the WCJ pointed out that the 2005 Schedule is rebuttable as indicated by Labor Code § 4660(c), which states that the rating schedule "shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." Further, the WCJ noted that the WCAB, as well as appellate courts, have consistently declined to imply a requirement that PD be rated in a rigid, lockstep fashion. To the extent that the AMA *Guides* express favor toward the combined values method, the WCJ observed that the Multiple Disabilities Table is a guide only and that physicians may, under certain circumstances, employ a different method of determining impairment if they remain within the four corners of the AMA *Guides* [See *Milpitas Unified School Dist. v. W.C.A.B.* (*Guzman*) (2010) 187 Cal. App. 4th 808, 115 Cal. Rptr. 3d 112, 75 Cal. Comp. Cases 837; *County of Los Angeles v. W.C.A.B.* (*LeCornu*) (2009) 74 Cal. Comp. Cases 645 (writ denied)].

Turning to Dr. Cheng's determination that simple addition of Applicant's left and right hip impairments provided a more accurate depiction of his overall impairment than application of the reduction formula, the WCJ stated in relevant part:

> Dr. Cheng points to the synergistic effect of one hip injury upon another opposite hip injury. I agree. It appears logical that a person who is able to compensate through the opposite member for an injury to one limb is to some extent less disabled or impaired than someone who cannot so compensate.

The WCJ continued:

> I remain persuaded that the QME has appropriately determined that the impairment resulting from applicant's left and right hip injuries is most accurately combined using simple addition than by use of the combined-values formula.

Regarding Defendant's assertion that it was not liable for increased compensation under Labor Code § 4658(d)(2), the WCJ disagreed that Applicant's return to his usual duties excused Defendant from its obligation to provide a timely return-to-work offer. According to the WCJ, the plain language of the statute requires a 15 percent increase in PD in *any* case when the return-to-work offer is not made within 60 days of a P&S report, even those cases in which the applicant has already returned to work.

While recognizing that the appellate court in *City of Sebastopol v. W.C.A.B.* (*Braga*) (2012) 208 Cal. App. 4th 1197, 146 Cal. Rptr. 3d 713, 77 Cal. Comp. Cases 783, held that requiring a defendant to provide a return-to-work notice to an employee who had already returned to work would frustrate the purpose of the statute and render an absurd result, the WCJ found this case distinguishable from *Braga*. In *Braga*, the employee missed no time from work before he was declared P&S. Here, on the other hand, Applicant incurred two periods of TD following his hip surgeries.



In assessing whether the holding in *Braga* ought to be broadened to include employees who suffer TD, the WCJ examined both the legislative intent and policy embraced in that decision, as well as the requirements of the return-to-work offer set out in Labor Code § 4658(d), as they applied to the case at hand, and reached the following conclusions:

> On the first point, to apply *Braga* to the facts of this case, as defendant would have us do, requires a measure of retrospection: By the time the return-to-work offer was triggered, the employer could see that applicant had already returned to his regular job, and therefore it could not be said to have an incentive to allow him so to return. However, at this point we have the benefit of additional hindsight: This employer did not, at that time or at any time since, provide any PD indemnity whatsoever, at any weekly rate. Thus, it cannot legitimately claim to have a lack of incentive to reduce a benefit it was not providing.
>
> With respect to the statutory and regulatory requirements of the return-to-work notice itself, it must be noted that there are several. The statute itself requires that the work last "at least 12 months." The regulation . . . sensibly clarifies that the position be "*expected* to last for a total of at least 12 months of work." (Emphasis added [*by WCJ*]) In addition, the regulation specifies that the offer of employment state the return-to-work date, the job title, the location and shift of the position, and the wage rate. It provides several reasons and an opportunity for the employee to reject the offer, object to its terms, or waive such objections. Were the application of *Braga* to be extended to employees who actually *do* [*Emphasis by WCJ*] return to work from temporary disability—that is, if such employees were not entitled to the same assurances as those whose return-to-work and P&S dates coincide—it would appear that the purposes of the statute and the regulation would be thwarted and there may in fact come to be a disincentive for the employee to return to work before that P&S date.
>
> I believe that, under the circumstances presented in this case, the statute must be interpreted literally.

Finally, the WCJ pointed out that, although nonbinding, several panel decisions support his award of increased compensation to Applicant in this case [See, *Jauregui v. Mercy Southwest Hospital*, 2008 Cal. Wrk. Comp. P.D. LEXIS 582; *Mansfield v. County of Los Angeles*, 2010 Cal. Wrk. Comp. P.D. LEXIS 53].

The WCAB denied reconsideration and adopted and incorporated the WCJ's report without further comment on the issues raised.

Defendant filed a Petition for Writ of Review, substantially contending that the WCAB erred in assessing Applicant's PD by adding the impairments to his left and right hips, and that the WCAB was not justified in awarding a 15 percent increase in PD pursuant to Labor Code § 4658(d)(2).

Applicant filed an Answer, contending in relevant respects that the WCAB did not err in calculating his PD by adding the left and right hip impairments as set forth by the panel QME, since this method most accurately reflected Applicant's impairment. Additionally, Applicant contended that the WCAB properly awarded a 15 percent increase in his PD compensation pursuant to Labor Code § 4658(d)(2) for Defendant's failure to provide a timely return-to-work offer. Applicant requested an award of reasonable attorney's fees and costs pursuant to Labor Code § 5801.

WRIT DENIED February 28, 2013. [*Editor's Note: The Court of Appeal's order did not indicate whether Applicant's request for attorney's fees was denied. It is assumed that the request was denied.*]

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Beneficial Services, Inc., Highlands Insurance Company, Petitioners v. Workers' Compensation Appeals Board, Employers Insurance Company, **Rosalie See**, Respondents

Civil No. G047769—Court of Appeal, Fourth Appellate District, Division Three

78 Cal. Comp. Cases 219, 2013 Cal. Wrk. Comp. LEXIS 24

January 31, 2013 Writ of Review Denied

*Prior History:* W.C.A.B. Nos. ADJ4704159 [AHM 0120563], ADJ2380068 [AHM 0102888], ADJ2217428 [AHM 0106492]—WCJ Patricia L. Frisch (AHM); WCAB Panel: Commissioners Moresi, Brass, Lowe [*see* See v. Beneficial Services, Inc., 2012 Cal. Wrk. Comp. P.D. LEXIS 707 (Appeals Board panel decision)]

*Disposition:* Petition for writ of review denied

*Counsel:* For petitioners—Nsahlai Law Firm, by Emmanuel Nsahlai

**Injury AOE/COE—WCAB held that applicant realtor sustained one specific injury AOE/COE on 1/25/2002 to her spine and both knees, had a fall on 10/13/2002 that was compensable consequence of 1/25/2002 injury, and did not sustain cumulative trauma injury AOE/COE, when WCAB found that agreed medical evaluator issued two reports with same date, one finding specific injury and one finding cumulative trauma injury, that WCAB relied on report finding specific injury, which was more consistent with applicant's credible testimony, that agreed medical evaluator testified that his office sent wrong report by mistake and again gave opinion that applicant had specific, not cumulative trauma, injury, and that agreed medical evaluator's opinions were substantial evidence and were more persuasive than opinions from panel qualified medical evaluator.** [See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 4.01[2], 4.02, 4.03.]

# MEMORANDUM

Date: 10/7/2015
To: All Work Comp Attorneys
From: Mike

**RE:** ***Kite* Decision**

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Hopefully, everyone understands the impact of the *Kite* decision on combining impairments by addition, rather than by the use of the Combined Value Chart. Recently, I sent to all of you a Decision from Shields were this was very effective. A 60% loss of function of an upper extremity was combined with the psychiatric impairment resulting in a 115% disability, limited, of course, to only a 100% permanent total disability award (See *Sandra Chambers'* case).

Attached is a note from Dr. Lieberman, who had seen the Applicant, America Guandique, prior to the *Kite* decision. The Applicant's physical disability rates out at a 47%. Dr. Lieberman's report rates out at 35%. Using the Combined Value Chart results in a 66% rating. Utilizing the *Kite* decision, results in an 82% award.

It is noteworthy that the physical injury involved the bilateral hands and bilateral shoulders, neck, and low back. The bilateral hands were combined by addition, as well as the bilateral shoulders, which significantly increased the ultimate rating orthopedically. In addition, the QME found that the disability regarding two separate injuries were inextricably intertwined. Therefore, there will be one rating rather than two separate ratings. I assume that everyone already knows all of this. This is simply a reminder. There will be no pop quiz.

MGG

Enclosure: Report of Richard Lieberman, M.D.