WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

STEPHEN SMITH, ***Applicant***

vs.

STATE OF CALIFORNIA, DEPARTMENT OF GENERAL SERVICES; legally uninsured; adjusted by STATE COMPENSATION INSURANCE FUND, ***Defendants***

Adjudication Number: ADJ7483164
Sacramento District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the December 12, 2025 Findings, Award and Order issued by the workers' compensation administrative law judge (WCJ). Therein, and as relevant here, the WCJ found that applicant sustained admitted injury arising out of and occurring in the course of employment (AOE/COE) to his bilateral upper extremities, hands and wrists, while employed as an Administrative Law Judge during the period through September 23, 2010. The WCJ further found that applicant's injury caused permanent total disability of 100%.

Defendant contends that the WCJ erred in finding 100% permanent disability arguing that the opinion of Nicole Chitnis, M.D., is not substantial evidence to rebut the strict scheduled rating and arguing that applicant's impairment should have been combined using the combined values chart (CVC) rather than added pursuant to the holds of *Athens Administrators v. Workers' Comp. Appeals Bd. (Kite)* (2013) 78 Cal.Comp.Cases 213 (writ den.) and *Vigil v. County of Kern (Vigil)* (2024) 89 Cal.Comp.Cases 686 (Appeals Board en banc).

We have considered the allegations of the Petition for Reconsideration, the Answer, and the contents of the WCJ's Opinion on Decision (Opinion) and Report and Recommendation on Petition for Reconsideration (Report) with respect thereto. Based on our review of the record, and for the reasons stated in the WCJ's Opinion and Report, both of which we adopt and incorporate as quoted below, and for the reasons stated below, we will deny reconsideration.

I.

Preliminarily, we note that former Labor Code[1] section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on January 14, 2026 and 60 days from the date of transmission is Sunday, March 15, 2026. The next business day that is 60 days from the date of transmission is Monday, March 16, 2026. (See Cal. Code Regs., tit. 8, § 10600(b).)[2] This decision is issued by or on Monday, March 16, 2026, so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to

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[1] All further statutory references are to the Labor Code, unless otherwise noted.

[2] WCAB Rule 10600(b) (Cal. Code Regs., tit. 8, § 10600(b)) states that:

> Unless otherwise provided by law, if the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

act on a petition. Section 5909(b)(2) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on January 14, 2026, and the case was transmitted to the Appeals Board on January 14, 2026. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the Report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on January 14, 2026.

II.

The WCJ stated the following in the Opinion:

> PERMANENT DISABILITY
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> Applicant has suffered an admitted injury to his bilateral upper extremities, wrists and hands.
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> Applicant was evaluated by Nicole Chitnis, M.D. as a "regular physician" per Labor Code §5701 in the specialty of Physical Medicine & Rehabilitation. Dr. Chitnis examined Applicant on July 8, 2019 (report dated August 7, 2019), August 8, 2022 (report dated August 31, 2022), April 11, 2023 (report dated April 15, 2023), November 7, 2023 (report dated November 11, 2023), and February 12, 2025 (report dated February 16, 2025) (Joint Exhibits 11, 8, 7, 5, and 4). Dr. Chitnis issued three supplemental reports dated April 2, 2020, February 20, 2021, July 4, 2023 (Joint Exhibit 10, 9 and 6). Dr. Chitnis was deposed on three separate occasions: October 19, 2019, May 22, 2024, and August 20, 2025 (Joint Exhibit 14, 13 and 12).
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> Dr. Chitnis assigned ratings using the strict application of the AMA Guides. For the right upper extremity, she opined 22% UE for loss of range of motion, 5% UE for carpal tunnel syndrome and 5% UE for radial styloidectomy, resulting in a combined impairment of 30% UE or 18% WPI for the right wrist. She also found 12% UE for loss of function of the medial nerve or 7% WPI and 13% UE for loss of ulnar nerve function or 8% WPI. (Joint Exhibit 7, pages 38-39). For the left upper extremity, Dr. Chitnis opined 16% UE for loss of range of motion, 5% UE for carpal tunnel syndrome and 5% UE for radial styloidectomy, resulting in a combined impairment of 24% UE or 14% WPI for the right wrist. She also found 12% UE for loss of function of the medial nerve or 7% WPI and 13% UE for loss of ulnar nerve function or 8% WPI. (Joint Exhibit 7, pages 39-40).

Dr. Chitnis explained why she felt that the strict rating did not accurately reflect Applicant's level of impairment. Applicant's pain and symptomology was greater than one would relate to a simple and straightforward diagnosis. Applicant developed severe pathology. He underwent multiple surgeries on the left side, but his symptoms have worsened instead of improved. Applicant also had several surgeries on the right. He was left with significant loss of function in both hands (Joint Exhibit 7, pages 40-41).

Dr. Chitnis provided two different methodologies for rating. The first methodology relied upon Table 16-18 utilizing the maximum impairment values for disorders to specific joints, expressly the wrist which is 36% WPI. Dr. Chitnis opined that Applicant suffered a 70% loss of function of the right wrist resulting in 25% WPI (70% x 36% WPI = 25% WPI) and 80% loss of function of the left wrist resulting in 29% WPI (80% x 36% = 29%) (Joint Exhibit 7, pages 41- 42). However, Dr. Chitnis noted that there was a prolonged course of treatment and continued deterioration with further loss of muscle strength and conditioning, so she provided a second methodology analogizing Figure 16-2 (impairment for upper extremity amputation) as the most accurate method of rating given the complexities of the case. Applicant underwent several surgeries and was left with significant symptomology and functional deficit. She opined that Applicant essentially lost 75% of the function of his arms below the elbow resulting in 43% WPI for each upper extremity (75% loss of function x 57% WPI for amputation distal to the elbow joint = 43% WPI) (Joint Exhibit 7, page 42). Subsequent reporting and deposition testimony by Dr. Chitnis confirmed her opinion as to 43% WPI for each upper extremity.

The question remains as to whether these impairments should be added or combined. Dr. Chitnis was asked to address the recent en banc decision, *Vigil v. County of Kern* (2024) 89 Cal. Comp. Cases 686. In her report dated February 16, 2025, Dr. Chitnis stated that the impairments should be added per *Vigil,* however, the explanation was scant. Her opinion was a single sentence stating that there were extensive difficulties with dressing, showering, shaving, buttoning, cooking, chopping vegetables, washing dishes, driving, "Thus, per *Vigil*, Mr. Smith has overlap with amplification and thus, his WPIs need to be added, rather than combined" (Joint Exhibit 4, page 28). Dr. Chitnis did not state "how/why" there was overlap or amplification.

Dr. Chitnis was deposed August 20, 2025 (Joint Exhibit 12). She confirmed her opinion on impairment and answered questions about the application of *Vigil*. She confirmed that this case follows the example given in *Vigil*, of an injured worker with impairment in both hands making the ability to button one's shirt even more difficult (*Id*, page 31:14-23; See also *Vigil, supra*, at page 692). Once of the critical aspects of the *Vigil* decision was the lack of discussion by the QME of the injured worker's Activities of Daily Living. In the present case, Dr. Chitnis wrote extensively about Applicant's Activities of Daily Living and

confirmed in deposition that she had extensive discussions with the Applicant about his Activities of Daily Living.

Applicant credibly testified at trial as to the symptoms experienced in both upper extremities and various limitations in performing day-to-day activities. His testimony was in line with the symptoms and ADL limitations noted by Dr. Chitnis. For these reasons, Dr. Chitnis' opinion utilizing the third methodology for rating impairment per Figure 16-2 is the most persuasive. Based on the foregoing, I am persuaded that Dr. Chitnis' opinion on impairment constitutes substantial medical evidence. Not considering apportionment, which will be discussed below, the permanent disability rates as follows:

Right Upper Extremity 16.01.01.02-43-[5]55-110E-52-60% PD

Left Upper Extremity 16.01.01.02-43-[5]55-110E-52-60% PD

60 + 60 = (120) 100% permanent disability before apportionment

APPORTIONMENT

In the initial evaluation report dated August 7, 2019, Dr. Chitnis opined that Applicant's disability was apportioned 10% to pre-existing non-industrial medical conditions, as well as nonindustrial activities of daily living and non-industrial recreational activities (Joint Exhibit 11, page 45). She did not find any apportionment to his work-related activities as a professor at community college (Id.). In May 2024 at deposition, Dr. Chitnis was asked questions by Defense counsel about prior sports activities, prior work history, subsequent work history, etc. She testified that she would need additional information to make a more accurate determination as to apportionment (Joint Exhibit 13, page 11:16 – 13:11, 14:1-15:4, 17:4-22). However, on cross-examination by Applicant counsel, she confirmed that in the absence of additional or available information her opinion remained at 10% apportionment to nonindustrial causes (Joint Exhibit 13, page 26:18-30:19). It does not appear from the record that the parties provided Dr. Chitnis with any further information. Based on review of the medical reports, deposition testimony and absence of additional information, I find that Dr. Chitnis' opinion on apportionment constitutes substantial medical evidence. Therefore, the ratings are as follows:

Right Upper Extremity 90 (16.01.01.02-43-[5]55-110E-52-60) 54% PD

Left Upper Extremity 90 (16.01.01.02-43-[5]55-110E-52-60) 54% PD

54 + 54 = (108) 100% permanent disability taking into account apportionment.

(Opinion on Decision, at pp. 1-5.)

The WCJ stated the following in the Report:

FACTS

Applicant filed an Application for Adjudication of Claim alleging a cumulative trauma injury through September 23, 2010, to his bilateral upper extremities, hands and wrists due to his work as an Administrative Law Judge for the State of California, Dept of General Services. The parties utilized Dr. Conrad Clifford as an Agreed Medical Evaluator. The case proceeded to trial on November 2, 2018. The trial judge issued a Findings of Fact & Order on February 1, 2019, stating that Dr. Clifford's opinion did not constitute substantial evidence for purposes of deciding the issues and order[ed] the appointment of Dr. Nichole Chitnis as a "regular physician" pursuant to Labor Code §5701.

The parties proceeded to a Mandatory Settlement Conference on September 23, 2025, where in the matter was set for trial on permanent disability, apportionment, medical treatment, attorney fees, and alleged temporary disability overpayment. The parties noted on the Pre-Trial Conference Statement additional issues of *Almaraz/Guzman* rating and addition versus CVC per *Kite* and *Vigil*.

A trial took place on November 13, 2025, wherein the parties presented their evidence, arguments and the injured worker's testimony on the issues of (1) permanent disability, (2) apportionment, (3) attorney fees and (4) whether there was a temporary disability overpayment from January 26, 2015, through April 5, 2015 (Minutes of Hearing, Summary of Evidence, dated November 13, 2025, Page 2, Line 22 to Page 3, Line 2).

On December 12, 2025, the undersigned issued a Findings, Award and Order finding that Applicant's injury caused permanent total disability of 100%, and reasonable value of services provided by Applicant's Attorney was 15% and awarded such. The issue of whether there was a temporary disability overpayment was deferred pending the parties' adjustment of benefits paid, with leave to return to the trial court if the parties were unable to do so and have the matter addressed further. Defendant is appealing the award of permanent total disability of 100%, contending that Applicant failed to carry his burden of proof to rebut the strict rating and that CVC should have been used in determining the final impairment rating.

DISCUSSION

THE MEDICAL RECORD COMBINED WITH APPLICANT'S CREDIBLE TESTIMONY ESTABLISHED BY PREPONDERANCE OF THE EVIDENCE THAT APPLICANT HAD REBUTTED THE STRICT RATING

Defendant argues that Dr. Chitnis did not explain why the strict rating did not accurately reflect Applicant's disability and did not appropriately explain how/why the alternative rating most accurately reflected Applicant's level of disability. There is nothing in Defendant's Petition for Reconsideration that appears to be particularly new or different than what was previously addressed in their Trial Brief which was reviewed and considered by the undersigned in arriving at the Findings, Award and Order.

First, Dr. Chitnis did provide a strict rating per the AMA Guides. In her initial report dated August 7, 2019 (Joint 11, pages 37-39), Dr. Chitnis provided a strict rating using range of motion, sensory and motor deficits, and radial styloidectomy. Dr. Chitnis provided strict ratings in her subsequent re-evaluation report dated April 15, 2023 (Joint 7, pages 38-40).

Second, Dr. Chitnis did explain why the strict rating did not accurately reflect the Applicant's disability. In her initial report, Dr. Chitnis stated that the strict rating did not accurately reflect Applicant's impairment because Applicant's pain and symptomology were greater than one would expect for a simple and straightforward diagnosis. She went on to discuss the development of severe pathology, surgical history, worsening of symptoms over time, loss of strength and deconditioning (Joint 11, pages 39-40).

Third, Dr. Chitnis provided an alternative rating using the four corners of the Guides. In the August 7, 2019 report, she provided an alternative rating using Table 16-18 and Figure 16-2 (Id. Pg 40-41). Dr. Chitnis reiterated her alternative rating in her subsequent report dated April 15, 2023 (Joint 7, pages 40-42), again using Table 16-18 and Figure 16-2[.]

Finally, Dr. Chitnis explained why the alternative rating most accurately reflected Applicant's level of disability. Defendant argues that Dr. Chitnis provided two alternative ratings, so which rating should be used? However, Dr. Chitnis did explain why the second methodology using Figure 16-2 was more appropriate. Applicant underwent several surgeries and was left significant symptomology and functional deficit (Joint Exhibit 7, page 42). She confirmed her use of the second alternative rating at deposition comparing someone with an amputation who would no longer be limited with ongoing pain versus Applicant who will be limited by pain, numbness, weakness, etc. (Joint Exhibit 12, 12:13 – 14:7, 16:6-14).

Defendant relies upon the Board's opinion in *Weaver v. Los Angeles Unified School District,* 2015 Cal. Wrk. Comp. P.D. LEXIS 766, for the proposition that a percentage loss of use of a body part does not automatically equate to the percentage of impairment for that body part. In the *Weaver* case, the AME provided an alternative impairment rating based on his view that the applicant had lost 50% use of her upper extremities – namely, that the maximum impairment of the upper extremity is 60% whole person impairment and because

applicant had lost 30% of use of each upper extremity, the AME assigned 30% impairment for each upper extremity. The injured worker was diagnosed with bilateral carpal tunnel syndrome and bilateral deQuervian's Tenosynovitis (trigger thumb), which are medical conditions that affect the wrists and hands, not the entire upper extremity. The Board did not follow the AME's alternative rating because the applicant failed to provide substantial evidence that she had lost the use of her entire upper extremity.

Here, the facts of *Weaver* are distinguishable. Dr. Chitnis did not provide an alternative rating based on the loss of use of the entire upper extremity. Dr. Chitnis provided a loss of function of the arms below the elbow (Joint Exhibit 7, page 42) based on a diagnosis of persistent bilateral carpal tunnel syndrome and cubital tunnel syndrome, which was confirmed in multiple reports and deposition testimony.

Also, Defendant contends that giving an award of permanent total disability to this injured worker is analogous to someone who has lost both hands or the use thereof under Labor Code §4662. Applicant did not argue permanent total disability per Labor Code §4662. Applicant argued permanent total disability based on the ratings provided by Dr. Chitnis under the AMA Guides based on the principles set forth in *Almaraz/Guzman* and *Vigil*. Defendant asserts Applicant can do some activities such as grocery shopping, light weightlifting, walking his dog, and consulting positions. However, Defendant fails to understand that Dr. Chitnis did not opine that the applicant fully lost both hands or the use thereof. She opined that there was loss of 75% of function of the arms below the elbow. She acknowledged that Applicant was able to do some activities but was severely limited so doing some things are good to maintain strength and flexibility and confirmed 75% loss of function (Joint Exhibit 12, 15:5 – 16:5). Dr. Chitnis opined that Applicant was worse off than someone who had an amputation because his condition is progressive with persistent pain, numbness and weakness, whereas someone with an amputation with prosthesis allows them to do more activities without pain (Joint Exhibit 12, 12:13 – 14:7, 16:6-14).

THE USE OF ADDITION AS OPPOSED TO THE USE OF CVC TO COMBINE APPLICANT'S DISABILITY IS SUPPORTED BY THE MEDICAL RECORD

Defendant argues that the CVC should have been used in determining the final impairment rating because Dr. Chitnis's opinions were not enough to deviate from using the CVC. She did not explain how and why, thus, Applicant failed to rebut the usage of CVC per *Almaraz/Guzman, Kite* and *Vigil*.

Dr. Chitnis opined that Applicant's impairments should be added (Joint Exhibit 4, page 28). During her deposition on August 20, 2025, Dr. Chitnis confirmed that Applicant's situation fell squarely in line with the example given in *Vigil* of

an individual with impairment in both hands making it more difficult to perform ADLs (Joint Exhibit 12, 31:14-23). Applicant testified credibly at trial as to the symptoms experienced in both upper extremities and various limitations in performing day-to-day activities, including the use of adaptive devices and his wife's assistance (Summary of Evidence, pages 5-6). His testimony was in line with the symptoms and ADL limitations noted by Dr. Chitnis which she went over with him during the examinations.

There is nothing in Defendant's Petition for Reconsideration or Defendant's Trial Brief which was reviewed and considered by the undersigned that changes the analysis, opinion or decision on the use of addition in arriving at a finding of permanent total disability.

RECOMMENDATION

It is respectfully recommended that the Petition for Reconsideration be denied.

(Report, at pp. 1-5, footnotes omitted.)

III.

Section 4660 provides that permanent disability is determined by consideration of whole person impairment within the four corners of the AMA Guides, as applied by the Permanent Disability Rating Schedule (PDRS) in light of the medical record and the effect of the injury on the worker's future earning capacity. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1321 [72 Cal.Comp.Cases 565] ["permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future earning capacity"]; *Department of Corrections & Rehabilitation v. Workers' Comp. Appeals Bd. (Fitzpatrick)* (2018) 27 Cal.App.5th 607, 614 [83 Cal.Comp.Cases 1680] (*Fitzpatrick*); *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd. (Guzman)* (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837] (*Guzman*).)

However, the scheduled rating is not absolute. (*Fitzpatrick, supra*, at pp. 619-620.) A rating obtained pursuant to the PDRS may be rebutted by showing an applicant's diminished future earning capacity is greater than that reflected in the PDRS. (*Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262 [76 Cal.Comp.Cases 624] (*Ogilvie*); *Contra Costa County v. Workers' Comp. Appeals Bd. (Dahl)* (2015) 240 Cal.App.4th 746 [80 Cal.Comp.Cases 1119] (*Dahl*).) In analyzing the issue of whether and how the PDRS could be rebutted, the Court of Appeal has observed:

> Another way the cases have long recognized that a scheduled rating has been effectively rebutted is when the injury to the employee impairs his or her rehabilitation, and for that reason, the employee's diminished future earning capacity is greater than reflected in the employee's scheduled rating. This is the rule expressed in *LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234 [193 Cal.Rptr. 547, 666 P.2d 989]. In *LeBoeuf*, an injured worker sought to demonstrate that, due to the residual effects of his work-related injuries, he could not be retrained for suitable meaningful employment. (*Id*. at pp. 237-238.) Our Supreme Court concluded that it was error to preclude LeBoeuf from making such a showing, and held that "the fact that an injured employee is precluded from the option of receiving rehabilitation benefits should also be taken into account in the assessment of an injured employee's permanent disability rating."
>
> (*Ogilvie, supra*, at p. 1274.)

Thus, "an employee may challenge the presumptive scheduled percentage of permanent disability prescribed to an injury by showing a factual error in the calculation of a factor in the rating formula or application of the formula, the omission of medical complications aggravating the employee's disability in preparation of the rating schedule, or by demonstrating that due to industrial injury the employee is not amenable to rehabilitation and therefore has suffered a greater loss of future earning capacity than reflected in the scheduled rating.' (*Ogilvie, supra*, at p. 1277.)

Moreover, pursuant to *Fitzpatrick, supra*, impairments "are generally combined" using the combined values chart (CVC) found in the permanent disability rating schedule (PDRS). However, the "scheduled rating is not absolute" and other methodologies may be used to calculate permanent disability. (*Id*. at p. 614.) Thus, while the PDRS is prima facie evidence of an employee's permanent disability, it is rebuttable. (*Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School Dist. (Almaraz-Guzman II)* (2009) 74 Cal.Comp.Cases 1084, 1106 (Appeals Board en banc); see *Blackledge v. Bank of America* (2010) 75 Cal.Comp.Cases 613 (Appeals Board en banc); *City of Sacramento v. Workers' Comp. Appeals Bd. (Cannon)* (2013) 222 Cal.App.4th 1360, 167 Cal. Rptr. 3d 1.) Ultimately, however, the goal in rating impairments is accuracy. (*Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd. (Almaraz-Guzman III)* (2010) 187 Cal.App.4th 808, 822 [75 Cal.Comp.Cases 837].)

In *Athens Administrators v. Workers' Comp. Appeals Bd. (Kite)* (2013) 78 Cal.Comp.Cases 213 (writ den.), the Appeals Board held that if there is substantial medical evidence that two or more impairments have a synergistic effect which causes the resulting impairment to be greater than that reflected through use of the CVC, the impairments should be added for purposes of

accuracy. In *Kite*, the applicant underwent bilateral hip replacement surgeries and the orthopedic QME opined that there was a "synergistic effect of the injury to the same body parts bilaterally versus body parts from different regions of the body," and, as such, "the best way to combine the impairments to the right and left hips would be to add them versus using the combined values chart, which would result in a lower whole person impairment." (*Id*. at p. 5.) Accordingly, in *Kite*, the WCJ found that the impairment for the applicant's hips should be added rather than combined.

Subsequent to *Kite*, the Appeals Board issued *Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686, 688–689 (Appeals Board en banc) wherein it was determined that if an applicant seeks to rebut the CVC and add rather than combine impairments, the applicant must establish that 1) the activities of daily living (ADLs) impacted by each impairment, and 2) the ADLs either do not overlap, or overlap in such a way that it increases or amplifies the impact of the overlapping ADLs.

Lastly, it is well established that decisions by the Appeals Board must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza, supra*; *LeVesque v. Workmen's Comp. Appeals Bd*. (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) "The term 'substantial evidence' means evidence which, if true, has probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion … It must be reasonable in nature, credible, and of solid value." (*Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd. (Bolton)* (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566], emphasis removed and citations omitted.) To constitute substantial evidence "… a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).) Furthermore, the physician must explain the nature of the disease and how and why it is causing disability at the time of the evaluation. (*Id*.)

We have given the WCJ's credibility determination great weight because the WCJ had the opportunity to observe the demeanor of the witness. *(Garza v. Workmen's Comp. Appeals Bd*. (1970) 3 Cal.3d 312, 318-319 [35 Cal.Comp.Cases 500].) Furthermore, we conclude there is no evidence of considerable substantiality that would warrant rejecting the WCJ's credibility determination. (*Id*.)

Based on the record in this case and for the reasons stated in the WCJ's Opinion and Report, as quoted herein, we agree with the WCJ's determination that Dr. Chitnis' opinion is substantial evidence, that the record supports addition of applicant's impairment pursuant to *Kite* and *Vigil*, and that applicant is 100% permanently and totally disabled. Accordingly, we deny reconsideration.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MARCH 16, 2026

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

STEPHEN SMITH
THE LAW OFFICES OF MARCUS & PULLEY, LLP
STATE COMPENSATION INSURANCE FUND

PAG/bp

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

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

RAUL RADILLA, *Applicant*

vs.

CARAVAN FOODS II, INC.;
GREAT AMERICAN INSURANCE CO., administered by STRATEGIC COMP,
Defendants

Adjudication Number: ADJ12660780
San Francisco District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the Findings of Fact and Award (F&A) of May 13, 2026, wherein the workers' compensation judge (WCJ) found in relevant part that applicant while employed by defendant, sustained injury arising out of and in the court of employment to his neck, low back, and left shoulder; applicant became permanent and stationary on July 19, 2023; that his injury resulted in 96% permanent partial disability; and that applicant's attorney is entitled to 15% of all indemnity awarded. The WCJ awarded applicant permanent partial disability of 96%, entitling applicant to 849.25 weeks of disability indemnity at the rate of $290.00 per week starting July 19, 2023, in the total sum of $246.282.50, less credit to defendant for all sums heretofore paid on account thereof, and less $36,942.37 payable to applicant's attorney, as attorney fees, to be commuted from the far end of the award if necessary; b) a life pension beginning 849.25 weeks after July 19, 2023, at the weekly rate of $278.31, subject to increases required under Labor Code[1] section 4659(c), less 15% payable to applicant's attorney, as attorney fees with jurisdiction reserved as to any commutation; and c) future medical treatment reasonably required to cure or relieve from the effects of the injury.

[1] All further statutory references are to the Labor Code unless otherwise noted.

Defendant contends that the WCJ erred in finding the QME's opinion regarding utilizing *Almaraz/Guzman* to increase the left shoulder and lower back impairment as substantial evidence and erred in finding that the impairments should be added rather than combined pursuant to the Combined Values Chart (CVC).

We have received an Answer from applicant. The WCJ prepared a Report and Recommendation on Petition for Reconsideration (Report), recommending that the Petition be denied.

We have considered the Petition for Reconsideration, the Answer, and the contents of the Report, and we have reviewed the record in this matter. Based on our review of the record, and for the reasons stated in the WCJ's report, which we adopt and incorporate, and for the reasons discussed below, we will deny defendant's Petition for Reconsideration.

I.

Up through July 1, 2024, petitions for reconsideration were subject to former section 5909, which provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.)

During the period from July 2, 2024 through June 30, 2026, petitions for reconsideration were subject to former section 5909, which stated in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
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> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a) (in effect from July 2, 2024 through June 30, 2026), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on July 2, 2026, and 60 days from the date of transmission is August 31, 2026. This decision is issued by or on August 31, 2026, so that we have timely acted on the petition as required by section 5909(a) (in effect from July 2, 2024 through June 30, 2026).

Section 5909(b)(1) (in effect from July 2, 2024 through June 30, 2026) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Section 5909(b)(2) (in effect from July 2, 2024 through June 30, 2026) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on July 2, 2026, and the case was transmitted to the Appeals Board on July 2, 2026. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) (in effect from July 2, 2024 through June 30, 2026), because service of the Report in compliance with section 5909(b)(2) (in effect from July 2, 2024 through June 30, 2026) provided them with actual notice as to the commencement of the 60-day period on July 2, 2026.

II.

The workers' compensation system includes compensation for permanent disability. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320.) "'[P]ermanent disability is understood as 'the irreversible residual of an injury.'" (*Id*. at p. 1320, quoting *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1111.) "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*, *supra*, at p. 1320, citing Lab. Code, § 4660(a).)

When assessing an injured employee's permanent disability, the first step is a comprehensive medical-legal report prepared by a treating or evaluating physician. (*Blackledge v. Bank of America* (2010) 75 Cal.Comp.Cases 613, 619.) The physician uses the AMA Guides to determine the whole person impairments (WPIs) for the applicant's medical conditions. (*Id*. at pp.

619-620.) The physician must set forth their reasoning behind the WPI. (*Id*. at p. 621.) "The expert opinion of a single physician may establish an injured employee's WPI, provided that the opinion constitutes substantial evidence. (*Id*. at p. 620, citing *Place v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 372, 378–379 [35 Cal.Comp.Cases 525, 529-539].) Permanent disability payments are then calculated by converting that degree of permanent disability into an award based on a table, the Permanent Disability Rating Schedule (PDRS). (*Department of Corrections & Rehabilitation v. Workers' Comp. Appeals Bd.* (*Fitzpatrick*) (2018) 27 Cal.App.5th 607, 611 [83 Cal.Comp.Cases 1680], citing *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1270 [76 Cal.Comp.Cases 624].)

The scheduled rating under the PDRS can be rebutted. (*Fitzpatrick*, *supra*, 27 Cal.App.5th at p. 619.)

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

(*Ogilvie*, *supra*, 197 Cal.App.4th at p. 1277.)

In *Almaraz v. Environmental Recovery Services* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc) (*Almaraz II*), we held that a "scheduled permanent disability rating may be rebutted by successfully challenging the component element of that rating relating to the employee's WPI under the AMA Guides….by establishing that another chapter, table, or method within the four corners of the Guides most accurately reflects the injured employee's impairment." (*Id*. at pp. 1095-1096.) In *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (*Guzman*) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837], the Court of Appeal affirmed our decision in *Almaraz II*.

Decisions of the Appeals Board must be based on substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) A medical opinion must be framed in terms of reasonable medical probability, it must be based on an adequate examination and history, it must not be speculative,

and it must set forth reasoning to support the expert conclusions reached. (*E.L. Yeager Construction v. Workers' Comp. Appeals Bd. (Gatten)* (2006) 145 Cal.App.4th 922, 928 [71 Cal.Comp.Cases 1687]*; Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 620-621 (Appeals Bd. en banc).) "Medical reports and opinions are not substantial evidence if they are known to be erroneous, or if they are based on facts no longer germane, on inadequate medical histories and examinations, or on incorrect legal theories. Medical opinion also fails to support the Board's findings if it is based on surmise, speculation, conjecture or guess." (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].)

On the other hand, there must be some solid basis in the medical report for the doctor's ultimate opinion; the Appeals Board may not blindly accept a medical opinion which lacks a solid underlying basis and must carefully judge its weight and credibility. (*National Convenience Stores v. Workers' Comp. Appeals Bd.* (*Kesser*) (1981) 121 Cal.App.3d 420, 426 [46 Cal.Comp.Cases 783].) In other words, the Appeals Board must look to the underlying facts of a medical opinion to determine whether or not that opinion constitutes substantial evidence, and accordingly, the expert's opinion is no better than the facts on which it is based. (*Turner v. Workers' Comp. Appeals Bd.* (1974) 42 Cal.App.3d 1036, 1044 [39 Cal.Comp.Cases 780].)

As explained by the WCJ in the Report, Dr. Chan's medical reporting constitutes substantial medical evidence to support an alternative rating within the four corners of the AMA Guides as Dr. Chan adequately explained why using the standard rating approach does not represent an adequate assessment given the impact on the activities of daily living (ADLs). (Report, pp. 5-6, 10-12; Jt. Ex. 1, QME Report of Raymond Chan, D.C. dated 6/29/24, pp. 2-4; Jt. Ex. 4, QME Report of Dr. Chan, dated 6/14/25, pp. 2-3; Jt. Ex. 5, Raymond Chan deposition dated 2/24/26, pp. 6-17, 25-26.)

III.

"Impairments to two or more body parts are usually expected to have an overlapping effect upon the activities of daily living, so that generally, under the AMA Guides and the PDRS, the two impairments are combined to eliminate this overlap." (*Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686, 691 (Appeals Board en banc.)) The PDRS contains the CVC, which uses a formula to take into account the overlapping effects on the ADLs. (*Id*.) *Vigil* provides the example of "impairments to the low back and the knee would likely both affect a person's physical activity,

ability to travel, and potentially other ADLs. In this example, the two impairments would then be combined in a way to eliminate this overlap. (*Id*.)

However, the CVC may be rebutted and the impairments added instead of combined, for example when "there was evidence showing no actual overlap between the effects on ADLs as between the body parts rated" and "where there is overlap, but the overlap creates a synergistic effect upon the ADLs." (*Vigil v. County of Kern*, *supra*, 89 Cal.Comp.Cases at p. 691.) "Where the medical evidence demonstrates that there is effectively an absence of overlap, the CVC table is rebutted, and it need not be used." (*Id*. at p. 692.)

Dr. Chan's medical reporting and testimony at his deposition constitutes substantial medical evidence to support adding applicant's impairments instead of combining them pursuant to the CVC. (Report, pp. 7-9, 12-13; Jt. Ex. 1, p. 4; Jt. Ex. 4, pp. 3-4; Jt. Ex. 5, pp. 17-23, 26-31.)

Accordingly, we deny defendant's Petition for Reconsideration of the May 13, 2026 Findings of Fact and Award.

For the foregoing reasons,

IT IS ORDERED that defendant's Petition for Reconsideration of the May 13, 2026 Findings of Fact and Award is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ PAUL F. KELLY, COMMISSIONER

I CONCUR,

/s/ CRAIG L. SNELLINGS, COMMISSIONER

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

AUGUST 31, 2026

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

RAUL RADILLA
LAW OFFICES OF NADEEM MAKADA
FINNEGAN, MARKS, DESMOND & JONES

JMR/*pm*

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

Report and Recommendation on Petition
for Reconsideration and Notice of Transmission to WCAB

INTRODUCTION

Defendant seeks reconsideration of May 13, 2026, Findings and Award (F&A). The substantive decision set forth therein was a finding of 96 percent permanent disability. In its petition, defendant contends my award was issued without or in excess of the appeals board powers, the evidence does not justify the Findings of Fact, and the Findings of Fact to not support the Order, Decision or Award. The petition is timely and verified. Applicant filed an answer.

FACTS

1. Procedural background.

This matter had previously proceeded to trial. In my April 23, 2025, Findings of Facts, Award, and Orders, I issued an order that the parties further develop the record and obtain supplemental reporting from the QME Ramond Chan, D.C. I also made a finding that applicant is entitled to further medical treatment to cure or relieve from the effects of the industrial injury. Applicant has an admitted industrial injury to his neck, low back, and left shoulder.

The matter proceeded to a second day of trial on April 20, 2026, with the parties submitting three additional joint exhibits.

2. Evidence at trial and decision.

Applicant testified in relevant part:

> He started working for the employer in 2003. On May 26, 2019, on the date of injury, he was working as a machine operator for the employer.
>
> In describing his injuries over the past 30 days, his left shoulder hurts. The pain is like a tense, tightening pain. The pain is constant in both the front and the back of his shoulder. The limitations he has because of the pain are: it is hard for him to bend, it hurts when he bends over, it hurts to lift with his arm, it hurts when it goes up. He can only lift his arm up to shoulder level. The heaviest object that he can lift is like a gallon of milk. It hurts more when he is sitting for too long, if he is standing for too long, and if he is lifting things. It hurts and the pain hits harder. He takes medication when the pain is bad: ibuprofen and acetaminophen. He has taken those since he got injured, so for five years. He will take the ibuprofen for a week and then stop. He takes the acetaminophen daily.

In his neck, the pain feels the same: tense pain, like stabbing pain. He feels the pain in the back of the neck where the bone is. The pain is constant. That is why he has to be straight or rest. Medication helps with his pain.

In his low back, the pain feels the same; it feels tense and tight, like something is pressing. The pain is constant. His limitations are: it is hard to stand up, to grab something, to lift something, and to bend over.

Regarding his activities of daily living, he has difficulty bathing: he has problems bending, and cleaning his feet. He is able to bathe by himself. He is left-handed. In the shower he is able to grab soap or shampoo with his left hand. He uses the right hand to turn on the shower. He gets dressed slowly so as to not hurt himself. He is able to put his clothes on by himself. He is able to button a dress shirt with his left hand. He is able to grab his clothes from the closet and/or any dressers if it is down low, but if it is high up then he has to use his right hand. It is hard to grab something that is high up. When he is getting dressed, he is able to zip up his pants with his left hand.

It hurts if he is sitting for too long. If he is standing for too long, he has to sit for a bit, then stand for a while. This is because of the back pain. Climbing stairs is hard because of the pain in his back. It hurts if he pushes – his left arm hurts and his back hurts. Regarding pulling, he has problems because of the pain in his arm and back. It hurts to sleep on his left side, he has to move because it hurts. Regarding household chores, he can make a simple meal such as in the microwave or heat up something. He is able to heat up food. He can cut with his right hand. He is able to use his left hand to use a fork and a spoon. He is able to heat something up. He hardly ever cooks, he just heats up things; he may make a sandwich. He cannot vacuum or mop. He is able to brush his teeth with his left hand. He is able to shave with his left hand, but with difficulty. He would be able to grab a razor with his left hand with a little bit of difficulty.

The injury was in 2019 and then he went back to work. The last day he worked was 6/26/2023. In 2022, he was treating with Dr. Alberto Retodo. He was working at times, and at times was not working. Sometimes he did, sometimes he did not.

He had shoulder surgery in 2021. He was told he needed another shoulder surgery but it is not operable at this time. He feels he got worse after the surgery because they did not do anything. He is aware he still has a large tear. They could not fix it.

(April 23, 2025 MOH/SOE.)

The parties offered several exhibits at the trials:

- Reports of QME Raymond Chan, D.C.

In his January 15, 2022, report, Dr. Chan reviewed and summarized several medical records. He summarized an August 19, 2019 MRI of the left shoulder as follows:

Impressions:

1. Full-thickness retracted tearing of the infraspinatus tendon and likely a small portion of [t]he adjacent supraspinatus tendon, with approximately 3cm of retraction and associated muscle atrophy.

2. Moderate acromioclavicular joint osteoarthritis with lateral acromial downsloping, predisposing to subacromial impingement.

3. Moderate glenohumeral joint osteoarthritis, with degenerative tearing of the labrum.

(p. 60.)

He noted applicant sustained injury to his left shoulder when using a long tool to scrape dough that fell off of a conveyor belt. Applicant eventually underwent debridement and subacromial decompression surgery on October 19, 2019. (pp. 35-36.)

Dr. Chan requested further diagnostic testing in the form of MRIs of the left shoulder and cervical spine. He also recommended electrodiagnostic studies "…to rule out plexopathy or peripheral neuropathy, [but applicant declined]…because he is afraid of needles." He diagnosed applicant with:

1. Massive irreparable rotator cuff tear of the left shoulder
2. Cervical strain/sprain
3. Left cervical radiculopathy vs. plexopathy
4. Adjustment disorder with mixed anxiety and depressed mood.

He stated applicant was not yet permanent and stationary. He commented, "Dr. Jensen's recommendation of superior capsule reconstruction is appropriate and will likely improve his shoulder function for the short and intermediate term." He gave work restrictions:

1. No repetitive motions of the bilateral wrists and hands.
2. Lifting, carrying and twisting not to exceed two pounds of the left hand
3. No use of the left arm above 60 degrees flexion and abduction.
(pp. 43-44)

In his August 8, 2023, report[1], Dr. Chan summarized a reevaluation of applicant. He added the diagnoses: lumbar sprain/strain, "a compensable consequence of shoulder injury". He noted:

> His lumbar strain and left radiculopathy are compensable consequence[s] of his left shoulder impairment. He was assigned to separate bagels on the production line. He stood eight hours by the conveyor belt and developed low back pain and left radiculopathy.

He noted applicant is permanent and stationary "as of the date of this report". He deferred the impairment rating and apportionment "until lumbar MRI and electrodiagnostic results are available." Regarding future medical treatment, he stated applicant will need conservative treatment with analgesics to treat his chronic pain, daily gentle exercises for his left shoulder to reduce stiffness, physical therapy, possible epidural injections, a TENS unit, left shoulder surgery, and psychological depression. (pp. 25-26.)

Dr. Chan provided work restrictions. He stated that applicant cannot return to his usual and customary work. (p. 26.)

Under the heading "Temporary Total Disability", Dr. Chan stated:

> Dr. Taylor, who initially operated on his shoulder, had placed the patient on temporary total disability after his rotator cuff surgery. Afterwards, his employer was accommodative for work restrictions and assigned the patient to take temperature of employees during the Covid pandemic.
>
> About four months ago (March 2023), he was transferred to the production area. He stood by the conveyor belt for eight hours each shift and [was] constantly using his left hand separating bagels that were stuck together. He experienced [an] increase of pain in the left shoulder and the low back. Dr. Retodo has recommended temporary total disability since 06/27/2023. I concur that the period of TTD is medically necessary.
>
> (p. 26.)

In his June 29, 2024, report, Dr. Chan addressed impairment ratings after reviewing diagnostic studies.

For the left shoulder, he assigned 15% WPI. He went on to state:

> Almaraz-Guzman Decision: It is my opinion that the straight rating by the Guides is not an accurate impairment.

[1] The report notes the date of the re-evaluation was July 19, 2023.

> On page 4 of the Guides, it states that "the whole person impairment percentages listed in the Guides estimate the impact of the impairment on the individual's overall ability to perform activities of daily living, excluding work, as listed in Table 1-2."
> …
>
> Within the four corner[s] of the Guides, the most accurate rating would be analogizing to Table 13-22, p. 343. Class 4 non-dominant extremity, with 35% WPI.
>
> Basis of opinion: Class 3 non-dominant hand…requires an individual can use the involved extremity but has difficulty with self-care activities. I would assign 29% WPI because of his massive irreparable rotator cuff tear affecting his [ADLs]. To further compensate for his impairment related to his work, a Class 4 with 24% WPI for the non-dominant hand is the most accurate rating for his left shoulder impairment including work impairment. The patient is precluded from using his glenhumeral joint for work activities.
>
> (pp. 2-3.)

For the cervical spine, Dr. Chan stated applicant has a "Cervical DRE Category II with 8% WPI." He assigned a 3% pain add-on "[t]o compensate for his extra burden of pain from TOX, grip loss and sensory loss in all digits." (pp. 3-4.)

For the lumbar spine, he stated: "Straight rating of the Guides: Lumbar DRE Category III with 13% WPI." He went on to state, under the heading "Almaraz-Guzman Decision:"

> It is my opinion that the straight rating is not an accurate rating because it does not include his work impairment. At work, prolonged standing, walking, repetitive bending and stooping are required. [⁋] He has lost his lifting capacity because of lumbar stenonsis and is precluded from heavy living. [⁋] The most accurate rating to address his [activities of daily living] and work impairment would be analogizing his lumbar impairment using the hernia chapter, Table 6.6, p. 163, Class 2 hernia with 19% WPI.
>
> (p. 4.)

Under the heading "Kite Decision", he stated

His cervical strain and rotator cuff injuries have adverse synergistic effects on his ADL. The trapezius assists the deltoid to raise his arm beyond 90 degrees. Dysfunction of the rhomboid

innervated by C5 would affect his scapular dyskinesia. I would therefore recommend addition instead of combining the cervical and shoulder impairments.

(p. 4.)

He reiterated his opinion regarding TTD and work status from his previous report. (p. 5.)

a. June 14, 2025, Report of QME Raymond Chan, D.C.

Joint Exhibit 4 is a supplemental report of QME Dr. Chan dated June 14, 2025. In his report, Dr. Chan made the following diagnoses:

- Massive irreparable rotator cuff tear of the left shoulder
- Cervical strain/sprain
- Left cervical radiculopathy vs. plexopathy
- Lumbar sprain/strain, a compensable consequence of shoulder injury

He assigned the following WPIs:

- Left shoulder: 35%
- Cervical spine DRE II: 8% + 3% pain add-on
- Lumbar spine DRE III: 13%; "By invoking Guzman, the most accurate rating is by analogizing his impairment to the hernia chapter with 19% WPI."

(p. 2.)

Dr. Chan went on to state that "the cervical and shoulder impairments [should] be added instead of…combined." He explained the mechanics of the manner in which the neck and shoulder impairments affect each other. He then stated that "the shoulder and the lumbar impairment should be added instead of being combined. Low back pain limits the ability to lift from the floor. The injured shoulder limits the ability to reach forward to [grasp] the object because of weakness and pain [in] the shoulder joint." (pp. 3-4.)

b. February 24, 2026, Deposition Transcript of QME Raymond Chan, D.C.

Joint Exhibit 5 is a deposition transcript of QME Dr. Chan dated February 24, 2026. Dr. Chan testified that his opinion regarding the WPI for the left shoulder remains the same at 35%. (pp. 6-13.) He stated his opinions remained the same for the WPIs for the cervical spine and lumbar spine as well. (pp. 13-25.)

Regarding whether the impairments should be combined versus added, Dr. Chan testified:

- The shoulder and lumbar impairments should be added rather than combined partially because both impairments independently limit similar activities of daily living such as lifting objects from the floor. Lumbar spine impairment restricts trunk flexion and lifting capacity. Shoulder impairment restricts reaching, grasping, and upper extremity strength. These limitations occur simultaneously during certain functional tasks. These impairments compound each other during any activities of daily living such as lifting, carrying, cleaning, or working at waist level.

- When a person attempts to lift an object from the floor, that activity requires coordinated lumbar flexion, core stability, and shoulder strength at the same time; one example might be lifting a box from a floor to a shelf, or lifting household objects to put on a shelf at home, or doing laundry. Making the bed would require repeated trunk flexion while tucking in sheets, sustained forward bending across the mattress, and twisting while walking around the bed. Shoulder involvement would be reaching across the bed to spread a blanket, lifting a mattress corner, or sustained arm elevation. Those would be amplified; that is an example of an ADL limitation.

- Grocery shopping for the lumbar spine impact would be lifting bags from the trunk of the car, bending to put the groceries away, carrying the weight of the grocery bag while walking. The shoulder impact would be carrying bags with sustained grip, reaching high shelves, controlling a load away from the body. That ADL would be amplified.

- Regarding bathing, the lumbar effects would be sustained by bending over a tub, bending to pick of soap or anything from the floor. For the shoulder, reaching forward repeatedly while bathing, holding or stabilizing one's weight while in a tub or shower, raising one's arm above one's head or hair level to wash oneself would be ADL limitations. Those ADLs would be amplified because of the shoulder and lumbar impairments.

- With respect to the cervical spine, he recommended adding the cervical impairment to the lumbar impairment because if a patient has cervical radiculopathy or spasm in addition to lumbar pain, attempts to compensate for lumbar discomfort such as shifting posture or pelvic tilt would increase strain in the cervical region.

(pp. 25-32.)

- <u>Reports of PTP Albert Retodo, M.D.</u>
  Applicant's Exhibit 1 is five reports of PTP Dr. Retodo.

In these reports, dated 02/11/2022, 03/21/2022, 06/22/2022, 08/01/2022, and 10/05/2022, Dr. Retodo made the following diagnoses: left shoulder tendon tear; left shoulder pain/weakness. He stated "modified work – per P&S (declared P&S on 10/18/2021.) He provided work restrictions, including no overhead or over-shoulder work with left upper extremity.

I issued my F&A and Opinion on Decision on May 13, 2026. I found applicant's permanent disability to be 96% based on the reporting and deposition testimony of QME Raymond Chan, D.C., and awarded such. I also awarded of attorney's fees.

3. *Contentions on reconsideration.*

In its petition for reconsideration, defendant contends this WCJ erred in relying on the reporting of QME Dr. Chan in his applications of Guzman and Vigil to applicant's impairment ratings because, defendant argues, it was not based on substantial medical evidence. Defendant contends that the combined values chart (CVC) should be utilized instead to determine applicant's permanent disability.

DISCUSSION

With respect to permanent disability, the applicant holds the burden of proof by a preponderance of the evidence. (Labor Code section 3202.5.)

1. *Guzman*

It is well established that while the PDRS is prima facie evidence of an employee's permanent disability, it is rebuttable. (Lab. Code, § 4660.1; *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School Dist. (Almaraz-Guzman II)* (2009) 74 Cal.Comp.Cases 1084.) In rebutting the AMA Guides, the doctor is expected to 1) provide a [standard] rating per the AMA Guides, 2) explain why the [standard] rating does not accurately reflect the applicant's disability, 3) provide an alternative rating using the four corners of the AMA Guides, and 4) explain why that alternative rating most accurately reflects applicant's level of disability.

The current state of the law on *Guzman* and its progeny appears to heavily favor medical opinions where the evaluator cites *Guzman* and attempts to arrive at the most appropriate rating, regardless of the exact "four corners" technique employed. Put another way, a physician's *Guzman* rating is to be followed so long as he used his expertise "to assess the impairment most accurately." *City of Sacramento v. Workers' Comp. Appeals Bd.* (Cannon) (2013) 79 CCC 1, 9. Dr. Chan's *Guzman* analysis is unrebutted.

Here, in his June 29, 2024, report, Dr. Chan addressed impairment ratings. He provided [standard] ratings per the AMA guides, explained why the [standard] ratings do not accurately

reflect applicant's disability, provided alternative ratings using the four corners of the AMA guides, and explained why those alternative ratings most accurately reflected applicant's level of disability:

> For the left shoulder, he assigned 15% WPI. He went on to state:
>
> Almaraz-Guzman Decision: It is my opinion that the straight rating by the Guides is not an accurate impairment.
>
> On page 4 of the Guides, it states that "the whole person impairment percentages listed in the Guides estimate the impact of the impairment on the individual's overall ability to perform activities of daily living, *excluding* work, as listed in Table 1-2.
> …
>
> Within the four corner[s] of the Guides, the most accurate rating would be analogizing to Table 13-22, p. 343. Class 4 non-dominant extremity, with 35% WPI.
>
> Basis of opinion: Class 3 non-dominant hand…requires an individual can use the involved extremity but has difficulty with self-care activities. I would assign 29% WPI because of his massive irreparable rotator cuff tear affecting his [ADLs]. To further compensate for his impairment related to his work, a Class 4 with 24% WPI for the non-dominant hand is the most accurate rating for his left shoulder impairment including work impairment. The patient is precluded from using his glenhumeral joint for work activities.
>
> (pp. 2-3.)

For the cervical spine, Dr. Chan stated applicant has a "Cervical DRE Category II with 8% WPI." He assigned a 3% pain add-on "[t]o compensate for his extra burden of pain from TOX, grip loss and sensory loss in all digits." (pp. 3-4.)

For the lumbar spine, he stated: "Straight rating of the Guides: Lumbar DRE Category III with 13% WPI." He went on to state, under the heading "Almaraz-Guzman Decision:"

> It is my opinion that the straight rating is not an accurate rating because it does not include his work impairment. At work, prolonged standing, walking, repetitive bending and stooping are required. [¶] He has lost his lifting capacity because of lumbar stenonsis and is precluded from heavy living. [¶] The most accurate rating to address his [activities of daily living] and work impairment would be analogizing his lumbar impairment using the hernia chapter, Table 6.6, p. 163, Class 2 hernia with 19% WPI.
>
> (p. 4.)

Dr. Chan explained that analogizing the lumbar impairment to a hernia was most accurate since increased pressure could lead to the lumbar disc bulge. (Joint Exhibit 5, pp. 14-15.)

In accordance with *Guzman*, Dr. Chan provided a thorough explanation based upon reasonable medical probability. Accordingly, I concluded that assignment of impairments under *Guzman* constitutes substantial medical evidence.

Regarding the pain add-on to the cervical spine, Dr. Chan testified there was no overlap between the pain add-on and the DRE II impairment. The undersigned found Dr. Chan's rating well-supported in his June 29, 2024, report, as he reviewed the MRIs, noted applicant's constant neck pain. He assigned a 3% pain add-on "[t]o compensate for his extra burden of pain from TOX, grip loss and sensory loss in all digits." (pp. 3-4.) I adopted the 3% pain add-on.

2. Vigil

Although the preferred method of combining impairments is using the Combined Values Chart ("CVC"), the impairments may be added if it is a more accurate reflection of the overall impairment because of the synergistic effect of the impairments. (*Athens Administrators vs. Workers' Comp. Appeals Bd. (Kite)* (2013) 78 Cal. Comp. Cases 213). In order to rebut the CVC, the applicant should establish the impact of each impairment on his activities of daily living ("ADLs") and that either there is no overlap between the effects on those ADLs for the rated body parts or there is overlap but it increases or amplifies the impact on the overlapping ADLs. (*Vigil v. County of Kern*, (2024) 89 Cal. Comp. Cases 686 *(en banc.)*

Dr. Chan explained that:

> His cervical strain and rotator cuff injuries have adverse synergistic effects on his ADL. The trapezius assists the deltoid to raise his arm beyond 90 degrees. Dysfunction of the rhomboid innervated by C5 would affect his scapular dyskinesia. I would therefore recommend addition instead of combining the cervical and shoulder impairments.

(Joint Exhibit 1, p. 4.)

In his deposition testimony, Dr. Chan outlined the numerous ADLs impacted by each impairment (Joint Exhibit 5.). I found his testimony on this issue to be substantial and persuasive. Defendant contends that the testimony is not substantial evidence, as applicant's counsel asked several leading questions to which Dr. Chan simply replied, "yes." A leading question may be asked of a witness on cross-examination or recross-examination. (Evid. Code, § 767.) Furthermore, there were no objections made to any of those questions. (pp. 53-59.) I found the CVC has been rebutted, and the impairments should be added.

I found the following permanent partial disability:

- Left shoulder: 35% (16.02.01.00 - 35 - [1.4] 49 - 320F - 49 - 51%) 51%

- Cervical spine DRE II: 11% (15.01.01.00 - 11 - [1.4] 15 - 320F - 15 - 16%) 16%

- Lumbar spine DRE III: 19% (15.03.01.00 - 19 - [1.4] 27 - 320F - 27 - 29%) 29%

= 51 + 16 + 29 = <u>96% permanent disability</u>

RECOMMENDATION

For the foregoing reasons, I recommend that defendant's Petition for Reconsideration, filed herein on June 8, 2026, be denied. This matter is being transmitted to the Appeals Board on the service date indicated below my signature.

Hillary R. Allyn
Workers' Compensation Judge
Workers' Compensation Appeals Board

The REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION AND NOTICE OF TRANSMISSION TO WCAB was filed and served on all parties listed in the Official Address Record pursuant to Rule 10628, and the case was transmitted to the Appeals Board on this date.

ON: July 2, 2026
BY: V. Chung

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

KEVIN BARRETO, *Applicant*

vs.

CITY OF VALLEJO, permissibly self-insured;
administered by LWP CLAIMS SOLUTIONS, INC., *Defendants*

Adjudication Number: ADJ13057169
San Francisco District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the Findings and Award (F&A) issued on December 4, 2025, wherein the workers' compensation administrative law judge (WCJ) found, in relevant part, that applicant, while employed by defendant on July 12, 2019 as a police officer, sustained injury arising out of and in the course of employment (AOE/COE) to the right leg, right knee, and low back, resulting in permanent disability of 62%, thereby entitling applicant to an award of future medical as well as payment of $106,502.50, at a rate of $290.00 per week for 359.25 weeks, less reasonable attorney's fees.

Defendant contends that the WCJ's adoption and reliance upon Agreed Medical Evaluator (AME) Andrew Burt, M.D.'s *Almaraz-Guzman* rating is an "improper deviation from the permanent disability rating schedule [(PDRS)]" and that use of the addition versus combined values chart (CVC) method of rating is "based on a conclusory theory of 'synergistic effect' that fails to satisfy the requirements of *Vigil* [*v. County of Kern* (2024) 89 Cal.Comp.Cases 686, 688-689 (Appeals Bd. en banc)]." (Petition for Reconsideration (Petition), pp. 10, 19.) Defendant further contends that the reporting of Dr. Burt is not substantial medical evidence because his opinions on complex regional pain syndrome (CRPS) are based upon "obsolete methodology," and "speculative reasoning." (Petition, p. 1.)

We have received an Answer from applicant and the WCJ prepared a Report and Recommendation on Petition for Reconsideration (Report), recommending that the Petition be denied.

We have considered the contents of the Petition, the Answer, and the Report, and we have reviewed the record in this matter. For the reasons discussed below, we will deny the Petition.

FACTS

On February 18, 2020, applicant filed an Application for Adjudication of Claim (Application) alleging that, while employed by defendant on July 12, 2019 as a police officer, he sustained injury AOE/COE to the right leg, right knee, and low back.

Applicant sought treatment with primary treating physician (PTP), Jeff Jones, M.D.

Thereafter, the parties agreed to use Dr. Burt as the AME. Dr. Burt evaluated applicant on two occasions and issued reports dated September 29, 2021, December 27, 2021, January 18, 2022, March 30, 2022, December 13, 2022, February 19, 2024, June 27, 2025, and July 21, 2025.

In his September 29, 2021 report, Dr. Burt diagnosed applicant with low back pain, radiculopathy, post-surgical lesions, and right lower extremity CRPS involving the infrapatellar branch of the saphenous nerve and common femoral nerve at the fibular head. (Exhibit 101, p. 7.)

In his January 18, 2022 supplemental report, Dr. Burt stated that, in accordance with page 553 of AMA Guides, "CRPS is currently believed to occur in the central nervous system, so the evaluator should use the station and gait impairment criteria in Table 13-15 to rate lower extremity impairments due to lesions in the central nervous system." (Exhibit 103, p. 3.) He provided a provisional rating of 19% whole person impairment (WPI) with a 3% add-on for pain and outlined limitations on activities of daily living (ADLs) including problems with positioning, sleep, depression, sexual dysfunction, and difficulty placing and removing footwear. (*Ibid*.)

In his December 13, 2022 report, Dr. Burt opined that applicant had reached P&S/MMI status. Applicant was assigned a 19% WPI for CRPS, based upon Table 13-15, and due to difficulties with ADLs, including placement and removal of lower body clothing and footgear. (Exhibit 105, p. 5.) A 3% pain add-on was included to account for applicant's pain-related depression, sexual dysfunction, and difficulties with positioning. (*Ibid*.) For the lumbar spine, applicant was assigned a 5% WPI under DRE lumbar category II due to loss of motion, muscle spasm, and non-verifiable radiculopathy. For the right knee, applicant was assigned a 2% WPI

using Table 17-31, due to patellofemoral pain and crepitation on examination. Dr. Burt recommended adding impairments "since [the] combination [method] does not adequately encompass the synergistic effects of injury to the various body parts." (*Id*. at p. 6.) Dr. Burt also found *Almaraz Guzman* to be applicable and provided an alternate 19% WPI for loss of lifting capacity using Table 6-9 and another 19% for alteration of station and gait using Table 13-15. (*Ibid*.) He argued that these ratings were more accurate "since the standard rating does not adequately encompass the effects of the injuries on ADLs. (*Ibid*.)

On March 29, 2024, Dr. Burt was deposed by the parties and testified, in relevant part, as follows:

> Q: Was there a specific criteria that you used to assess if the applicant had CRPS?
>
> A: Yes.
>
> Q: And what was that criteria?
>
> A: First of all, I've reviewed the history, rather typical for the development of CRPS in an extremity. Secondly, I did repeated physical examinations considering the subjective complaints compatible with CRPS such as stabling, burning, intolerance to cold, intolerance to temperature changes, especially cold, and the physical findings which were consistent and included temporal—temperature differential in the skin, cool to the touch, cyanosis and mottling of the skin in the appropriate nerve distribution on the injured side and scarring consistent with the history of the trauma dog bite and the prior problem with the right knee. There was also edema and—let's see—some—some atrophy to the injured lower extremity musculature.

(Exhibit 109, pp. 11:24-12:18.)

***

> Q: Do you think that it would be—would you defer—that being the case, since you're unfamiliar with the Budapest criteria, would you defer to a pain management specialist in terms of the CRPS diagnosis?
>
> A: I wouldn't defer in terms of diagnosis. I would defer in terms of treatment. The diagnosis is secure in my opinion as the Agreed Medical Evaluator.

(*Id*. at pp. 18:19-19:1.)

***

> Q: Okay. So is it your testimony, just to confirm, that your diagnosis of CRPS is based upon the literature—the AMA Guides?

A: Based on the history, the physical examination, the physical findings, the complaints that applicant has relevant to that type of trauma, and the review of the medical that I had, the findings applied to the AMA Guides criteria.

Q: And it's also your opinion that there's a synergistic effect between the lumbar spine and the right lower extremity. Can you explain how you arrived at that conclusion?

A: And the knee.

Q: Okay. So how did you arrive at that conclusion?

A: Well, there was an initial injury to the knee. That would affect his ability to squat, kneel, run, jump, climb, heavy—carry heavy objects. Basically that injury and the compensable consequence from that injury which led to CRPS aggravated or further diminished his capacities along those lines. Then he developed the back pain due to alteration of his gait and use of the injured lower extremity.

Q: Okay.

A: And that's also synergistic because it affects his ability to bend, lift, squat, knee, climb, walk, and that sort of thing. In other words, he's not be able to—going to be able to work in law enforcement anymore.

Q: So your findings of synergistic effect, I'm sorry, is that based upon his subjective complaints to you?

A: Yes, along with consideration of the history, the physical findings and the medical records reviewed. It was all put together.

(*Id*. at pp. 22:23-24:8.)

***

Q: Okay. So—so under the Almaraz/Guzman analysis, you invoke the hernia table even though there is no hernia; correct?

A: That's right.

Q: And can you explain your reasoning for that?

A: Because there's a loss of lifting capacity due to the injuries to the spine and the lower extremities and the cervical—the cerebral cortex. Even though there's no abdominal herniation, he has loss [sic] lifting capacity due to these conditions and that loss of lifting capacity does contribute to the—let's see. The wording is "loss

of lifting capacity interfering with some activities of daily living," even though there's no abnormal abdominal herniation. It's an analogous rating.

Q: Okay. So along those lines, if, hypothetically, he doesn't have CRPS, can the same analogy apply to the station and gait table that you're referencing in the Almaraz/Guzman section of your report on page 6?

A: If he doesn't have CRPS?

Q: Yeah. If he doesn't have CRPS, would it—would it be appropriate to use the station and gait table by analogy?

A: If there were no signs or symptoms of CRPS, yes that's what I'd do.

Q: Okay. So if there were no CRPS, your Almaraz/Guzman ratings and analysis would not change; is that correct?

A: That's correct.

(*Id*. at pp. 27:21-28:25.)

***

Q: Okay. With respect to your discussion of the synergistic effect between the body parts is that you mentioned in your reporting the impact on lifting. Can you—can you describe that in a little more detail, and how do the three body parts work together, well, if they do work together as far as lifting goes?

A: Well if you're lifting anything more than few pounds, you have to use your back and your lower extremities if you're doing it correctly…

Q: …Yeah. So if someone—someone who has these three different body parts injured, is their ability to lift and the impact on daily—activities of daily living great than, let's say, if someone just had CRPS or a—or a right lower extremity injury without having any lower back involvement?

A: There's a synergistic effect in that injuries to the low back, the right knee and, in this case, the central nervous system are intertwined, and they affect his ability to bend, lift, climb, run, jump. Every one of them does. So there a synergistic effect over and above what would be there if there was only injury to one body part.

(*Id*. at pp. 32:21-34:3.)

After Dr. Burt's deposition, Dr. Jones issued a letter dated April 9, 2024, in response to an inquiry from the defense attorney. Dr. Jones indicated that applicant did not have CRPS, but admitted that the findings were not "more definitive" because he was forced to rely upon past

reporting (applicant had not been reevaluated since 2023). (Exhibit 113.) He noted also that "there is no characteristic diagnostic test" for CRPS, and that "CRPS is primarily a clinical diagnosis with classical physical findings, which generally use[s] the Budapest criteria to evaluate the clinical diagnosis." (*Ibid*.)

Thereafter, Charles Xeller, M.D. was retained as the Independent Medical Evaluator (IME). Dr. Xeller evaluated applicant on at least one occasion and issued reports dated March 21, 2025, April 15, 2025, and June 13, 2025.

In his March 21, 2025 report, Dr. Xeller indicated that applicant had reached P&S/MMI status, and that in accordance with *Almaraz-Guzman*, applicant sustained a 19% WPI under Table 13-15 for station and gait disorder and due to ADL restrictions. (Exhibit B, p. 32.) These findings did not include analysis of the lumbar spine.

In response to two additional letters from the defense attorney, Dr. Burt issued a further July 21, 2025 supplemental report underscoring that he would not change his findings or defer to Dr. Jones. In referencing a quote from Dr. Zwerin, he argued that "clinical judgement must be applied" because the persons who "authored these criteria failed to consider" and "probably did not even know" that "causalgia/reflex sympathetic dystrophy/chronic regional pain syndrome is a process" and "symptoms…will vary in intensity and character from time to time until the entire condition has fully developed." (Exhibit 108, p. 4.)

On August 4, 2025, applicant filed a Declaration of Readiness to Proceed for a mandatory settlement conference on the issues of permanent disability and future medical treatment.

The matter proceeded to hearing on September 8, 2025, and was set for trial on October 21, 2025.

At trial, the issues set for determination included permanent disability and attorney's fees. The parties stipulated, in relevant part, to injury AOE/COE to the right leg, right knee, and low back as well as a need for continued future medical. The parties submitted as joint exhibits, the reports of Dr. Burt and Dr. Jones, with the exception of Dr. Jones's March 13, 2023 report, which applicant submitted as evidence. Defendant submitted as evidence, the reports of Dr. Xeller, as well as a letter from DRI – Elk Grove dated March 15, 2023.

On December 3, 2025, the WCJ issued an F&A wherein the WCJ found, in relevant part, that applicant, while employed by defendant on July 12, 2019 as a police officer, sustained injury AOE/COE to the right leg, right knee, and low back resulting in 62% permanent disability,

entitling applicant to an award of future medical as well as payment in the amount of $106,502.50, at a rate of $290.00 per week for 359.25 weeks, less reasonable attorney's fees.

It is from this F&A that defendant seeks reconsideration.

DISCUSSION

I.

Preliminarily, former Labor Code[1] section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected under the Events tab in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on January 12, 2026, and 60 days from the date of transmission is March 13, 2026. This decision was issued by or on March 13, 2026, so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to

[1] All further statutory references will be to the Labor Code unless otherwise indicated.

act on a petition. Section 5909(b)(2) provides that service of the Report and Recommendation shall constitute notice of transmission.

Here, according to the proof of service for the Report, it was served on January 12, 2026. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that service of the Report provided accurate notice of transmission under section 5909(b)(2) because service of the Report provided actual notice to the parties as to the commencement of the 60-day period on January 12, 2026.

II.

Defendant contends that the WCJ's adoption of Dr. Burt's *Almaraz-Guzman* rating was an "improper deviation from the permanent disability rating schedule." (Petition, p. 10.)

It is well established that while the PDRS is prima facie evidence of an employee's permanent disability, it is rebuttable. (Lab. Code, § 4660.1; *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School Dist.* (*Almaraz-Guzman II*) (2009) 74 Cal.Comp.Cases 1084, 1106 (Appeals Bd. en banc); see *Blackledge v. Bank of America* (2010) 75 Cal.Comp.Cases 613 (Appeals Bd. en banc); *City of Sacramento v. Workers' Comp. Appeals Bd.* (*Cannon*) (2013) 222 Cal.App.4th 1360.) In *Almaraz-Guzman II*, we held that a "scheduled permanent disability rating may be rebutted by successfully challenging the component element of that rating relating to the employee's WPI under the AMA Guides….by establishing that another chapter, table, or method within the four corners of the Guides most accurately reflects the injured employee's impairment." (*Almaraz II*, *supra*, at pp. 1095-1096.) In *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (*Guzman*) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837], the Court of Appeal affirmed our decision in *Almaraz II* and noted that the end goal in rating impairments is ultimately accuracy.

In rebutting the AMA Guides, the doctor is expected to 1) provide a strict rating per the AMA Guides, 2) explain why the strict rating does not accurately reflect the applicant's disability, 3) provide an alternative rating using the four corners of the AMA Guides, and 4) explain why that alternative rating most accurately reflects applicant's level of disability. (*Id*. at 828-829.)

Here, in his December 13, 2022 report, Dr. Burt provided strict AMA Guides ratings for applicant's right knee, right lower extremity CRPS, and lumbar spine. Dr. Burt also invoked *Almaraz Guzman II*, and provided the following explanation with respect to his alternate ratings:

> The applicant has lost a significant amount of lifting capacity due to injuries to his back and right lower extremity. He estimates about 70%-80%. Table 6-9 on Page 136 of the AMA Guides (Class 2) applies by analogy. This classification allows a 10% - 19% range of impairment of the whole person for loss of lifting capacity due to abdominal herniation. There is no herniation in this case, but there is frequent discomfort, precluding heavy lifting, but not hampering some activities of daily living. Clinical judgment places the level of impairment at the upper end of the range or 19% by analogy since the central nervous system and a major weight-bearing joint are involved.
>
> In addition, Table 13-15 on Page 338 (Class 2) applies by analogy. This classification allows a 10%-19% range of impairment of the whole person. The individual rises to a standing position, walks some distance with difficulty and without assistance, but is limited to level surfaces. Clinical judgment places the level of impairment at the upper end of the range or 19% because of the central and spinal involvement.
>
> The impairments for loss of lifting capacity and alteration of station and gait are additive for 19% whole person impairment by analogy. The analogous rating provides a more accurate description since the standard rating does not adequately encompass the effects of his injuries on activities of daily living. The whole person impairment with the analogous rating is 38%.

(Exhibit 105, p. 6.)

In accordance with *Almaraz-Guzman II*, Dr. Burt provided a thorough explanation based upon reasonable medical probability. Accordingly, we conclude that Dr. Burt's assignment of impairment under *Almaraz II* constitutes substantial medical evidence.

III.

Defendant further contends that the WCJ's adoption of Dr. Burt's additive method of rating is "based on a conclusory theory of 'synergistic effect' that fails to satisfy the requirements of *Vigil*." (Petition, p. 19.)

In *Athens Administrators v. Workers' Comp. Appeals Bd.* (*Kite*) (2013) 78 Cal.Comp.Cases 213 (writ den.), the Appeals Board held that if there is substantial medical evidence that two or more impairments have a synergistic effect which causes the resulting impairment to be greater than that reflected through use of the CVC, the impairments should be added for purposes of accuracy. In *Kite*, the applicant underwent bilateral hip replacement surgeries and the orthopedic QME opined that due to a "synergistic effect of the injury to the same body parts bilaterally versus body parts from different regions of the body," "the best way to combine the impairments to the

right and left hips would be to add them versus using the combined values chart, which would result in a lower whole person impairment." *(Id*. at p. 5.) Accordingly, the WCJ in *Kite* found that the impairment for the applicant's hips would be calculated based upon the addition method rather than through the combined values formula.

Subsequent to *Kite*, the Appeals Board issued the en banc case of *Vigil* wherein it was determined that if an applicant seeks to rebut the CVC and add rather than combine impairments, the applicant must establish 1) The ADLs impacted by each impairment, and 2) That the ADLs either do not overlap, or overlap in such a way that it increases or amplifies the impact of the overlapping ADLs. (*Vigil*, *supra*, at pp. 688-689.)

Here, in addition to the explanation provided in his December 13, 2022 report, Dr. Burt testified as follows with respect to use of the addition versus CVC method for rating impairments:

> A: Well, there was an initial injury to the knee. That would affect his ability to squat, kneel, run, jump, climb, heavy—carry heavy objects. Basically that injury and the compensable consequence from that injury which led to CRPS aggravated or further diminished his capacities along those lines. Then he developed the back pain due to alteration of his gait and use of the injured lower extremity.
>
> Q: Okay.
>
> A: And that's also synergistic because it affects his ability to bend, lift, squat, knee, climb, walk, and that sort of thing. In other words, he's not be able to—going to be able to work in law enforcement anymore.
>
> Q: So your findings of synergistic effect, I'm sorry, is that based upon his subjective complaints to you?
>
> A: Yes, along with consideration of the history, the physical findings and the medical records reviewed. It was all put together.
>
> Dr. Burt later explained that:
>
> There's a synergistic effect in that injuries to the low back, the right knee and, in this case, the central nervous system are intertwined, and they affect his ability to bend, lift, climb, run, jump. Every one of them does. So there is a synergistic effect over and above what would be there if there was only injury to one body part.

(Exhibit 109, pp. 22:23-24:8, 33:22-34:3.)

Based upon the above explanations from Dr. Burt, we believe that applicant fulfilled the requirements outlined under *Vigil* to successfully rebut the CVC.

IV.

Lastly, defendant contends that the reporting of Dr. Burt lacks substantial medical evidence because his findings on CRPS are based upon "obsolete methodology" and "speculative reasoning." (Petition, p. 1.)

We remind the parties that during his March 29, 2024 deposition, Dr. Burt specifically testified that even if applicant had no CRPS and "no signs or symptoms of CRPS," his *Almaraz-Guzman* analysis would remain unchanged due to applicant's loss of lifting capacity and alteration of station and gait. (Exhibit 109, pp. 26:21-28:25.)

Notwithstanding the above, we note also that the existence of the "Budapest Criteria" does not close the door on other avenues for diagnoses. In his April 19, 2024 report, Dr. Jones states that the criteria are "generally" used for diagnosis, but he does not allege that they supersede the AMA Guides. (Exhibit 113.) Further, his own opinion is lacking in that he readily admits to reliance on past reporting given applicant's reluctance to a reevaluation. (*Ibid*.) Dr. Xeller's reporting is similarly lacking in that there contains no analysis or evaluation of the lumbar spine. As noted by Dr. Burt above, it is overlap in limitations to both the right lower extremity *and* the lumbar spine, which have contributed to applicant's increased impairment.

Further, the parties presumably chose Dr. Burt as an AME because of his expertise and neutrality; his opinion should therefore be followed unless there is good cause to find it unpersuasive. (*Power v. Workers' Comp. Appeals Bd.* (1986) 179 Cal.App.3d 775, 782 [51 Cal.Comp.Cases 114].) Here, the WCJ held that the opinions of Dr. Burt constitute substantial medical evidence, and we find no basis upon which to disagree.

Accordingly, we deny defendant's Petition.

For the foregoing reasons,

IT IS ORDERED that defendant's Petition for Reconsideration of the December 3, 2025 Findings and Award is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

I CONCUR,

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

/s/ KATHERINE A. ZALEWSKI, CHAIR

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MARCH 12, 2026

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

KEVIN BARRETO
BROWN & DELZELL, LLP
MICHAEL SULLIVAN & ASSOCIATES LLP

RL/*cs*

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

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

RUBY FREEMAN, *Applicant*

vs.

THE HERTZ CORPORATION; ACE AMERICAN INSURANCE COMPANY, administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., *Defendants*

Adjudication Number: ADJ10715566
Oakland District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration to allow us time to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.[1]

Applicant seeks reconsideration of the Findings & Award (F&A) issued on September 13, 2022, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant sustained industrial injury while employed by defendant on March 19, 2014 to her low back, resulting in 51% permanent disability.

Applicant contends that the WCJ erred in rejecting the opinion of Vocational Expert (VE) Frank Diaz, CDMS, who concluded that applicant sustained 100% permanent disability due to lack of amenability to vocational rehabilitation. In addition, applicant contends that the apportionment finding was legally erroneous because defendant failed to carry its burden of proof, as the opinion of Panel Qualified Medical Evaluator (PQME) Wayne E. Anderson, D.O., was not substantial medical evidence.

We have received an Answer from defendant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending we deny reconsideration.

[1] Commissioner Sweeney was on the panel that issued the order granting reconsideration. Commissioner Sweeney no longer serves on the Appeals Board. A new panel member has been appointed in her place.

We have considered the allegations in the Petition and defendant's Answer and the contents of the WCJ's Report with respect thereto. Based on our review of the record and the reasons discussed below, as our Decision After Reconsideration, we amend the F&A to reflect that applicant sustained 100% permanent disability and defer the issue of attorney fees. We otherwise affirm the F&A.

BACKGROUND

Applicant, while employed by defendant as transporter on March 19, 2014, sustained industrial injury to her low back.

The parties jointly submitted into evidence the Functional Capacity Evaluation (FCE) report of Rachel Feinberg, PT, DPT, dated November 30, 2020. (Joint Ex. 100.) Applicant submitted into evidence the PQME reports of Dr. Anderson (App. Exs. 1-5) and the VE reports of Mr. Diaz. (App. Exs. 6-11.) Defendant submitted into evidence the VE reports of Lisa Suhono, M.S. (Def. Exs. B-C.)

In his report dated January 10, 2018, PQME Dr. Anderson, after evaluating applicant, took a history that applicant fully recovered from prior motor vehicle accidents and had no residual symptoms when she sustained an industrial injury on March 19, 2014. On that date, while driving a company vehicle and exiting a freeway in Richmond, she was rear-ended. The impact caused her vehicle to spin and block a lane. (App. Ex. 1, pp. 15.)

PQME Dr. Anderson reviewed and summarized applicant's medical records. The records reflected that, following the March 19, 2014 rear-end motor vehicle accident, applicant immediately reported neck, thoracic spine, lumbar spine, right shoulder, and right leg pain and received diagnoses of multiple cervical, thoracic spine, and lumbar spine strains. Despite conservative treatment, including medications, physical therapy, chiropractic care, acupuncture, and multiple lumbar epidural steroid injections, she continued to experience significant low back pain with right-sided radiculopathy, weakness, and limited tolerance for standing and walking. (*Id.* at p. 22.) Imaging studies revealed L4-L5 spondylolisthesis, disc bulges, spinal stenosis, and nerve root compression, particularly affecting the right L4 and L5 nerve roots. (*Id.* at pp. 24-25.) Her symptoms progressively worsened and, on April 9, 2015, Michael David Tseng, M.D., performed a bilateral L4-L5 posterior spinal fusion, right L5-S1 laminectomy, and right L4-L5 transforaminal lumbar interbody fusion. (*Id.* at pp. 32-33.) Postoperatively, although

she initially showed improvement, she continued to report intermittent low back pain, right leg pain, weakness, and episodes of her right leg "giving out." (*Id.* at pp. 39-42.) Follow-up CT and MRI imaging confirmed solid fusion at L4-L5 but demonstrated ongoing degenerative changes, foraminal stenosis at L5-S1 with contact of the right L5 nerve root, and multilevel disc bulging. (*Id.* at pp. 39-40.)

With respect to permanent disability, PQME Dr. Anderson opined that applicant has 28% whole person impairment (WPI) based on DRE Lumbar Category V under Table 15-3 on page 384 of the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides). She underwent a lumbar fusion, resulting in loss of motion segment integrity that places her in DRE Lumbar Category IV, and developed recurrent radiculopathy with motor weakness supported by MRI findings, placing her in DRE Lumbar Category III. Because both Categories III and IV are present, the AMA Guides directly place her in DRE Lumbar Category V, which allows up to 28% WPI based on limitations in activities of daily living (ADLs). (*Id.* at p. 48.)

Alternatively, PQME Dr. Anderson outlines a transition from the DRE method to the Range of Motion (ROM) method for evaluating the lumbar spine involving multiple-level pathology and bilateral radiculopathy. To reach the final 30% WPI, he followed a multi-step computational process pursuant to the AMA Guides. Under step one, in the "physical examination," he documented specific inclinometer readings: 60° flexion (or 2% WPI) and 25° extension (or 3% WPI), which he applied to Table 15-8 on page 407, 20° left/right lateral bending (or 2% WPI), and Table 15-9 on page 409. (*Id.* at p. 20.) Summing the results from these motion tables produced a 7% WPI for mobility. Next, he assessed neurologic deficits using Table 15-18 on page 424. Citing "4/5" and "4-/5" strength in plantar flexion and dorsiflexion, he assigned a Grade 4 motor deficit. Despite Table 15-2 on page 376 mapping plantar flexion to the S1 nerve root, he elected to rate all the findings under the L5 nerve root. By multiplying the observed deficits against the maximum L5 motor value (37%), rather than the S1 nerve root (20%), and maximum sensory value (5%) under Table 15-18 on page 424, he calculated 11% WPI for motor loss and 3% WPI for sensory loss. He then added these three exam-based components (7% + 11% + 3%) to reach a subtotal of 21% WPI. Under step two, utilizing Table 15-7 on page 404 under Section IV (D), he assigned 12% WPI based on a single-level spinal fusion with residual symptoms. To conclude the rating, he utilized the combined values chart (CVC) to merge the 21% WPI with the 12% WPI to arrive at 30% WPI. (*Id.* at pp. 48-50.)

PQME Dr. Anderson finally determined impairment based on gait derangement as an analogous approach under *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc) (*Almaraz/Guzman II*) assigning 40% WPI under Table 17-5 on page 529 of the AMA Guides, reflecting moderate severity requiring routine use of two canes or two crutches. He explained that the strict ROM rating of 30% WPI does not fully capture the true functional impact of the lumbar spine condition because that methodology relies in part on subjective assessments of sensory loss and motor strength and may undervalue the degree to which the lumbar pathology affects the lower extremities. Although the strict method accounts for some radicular symptoms, it does not adequately reflect applicant's significant functional limitation, particularly the persistent abnormal gait and the regular need for a walker, functionally equivalent to two canes. Because these objective gait abnormalities demonstrate substantial impairment in ambulation caused by the lumbar spine condition and its bilateral radiculopathy, PQME Dr. Anderson concluded that the gait derangement methodology, resulting in a 40% WPI, more accurately reflects the overall severity of applicant's disability than the strict ROM rating. (*Id.* at pp. 51-52.)

With respect to apportionment, PQME Dr. Anderson explained that recent imaging showed mild degenerative changes, which slightly affect future disability and medical needs, but their impact is limited. Accordingly, he assigned 90% of the lumbar spine impairment to the industrial injury and 10% to preexisting degenerative changes. (*Id.* at p. 45.)

In his supplemental report dated September 4, 2018, PQME Dr. Anderson opined that applicant's objectively documented abnormalities significantly limit standing, walking, and sitting and preclude activities such as climbing, forward bending, kneeling, and crawling. Although she retains the ability to perform upper extremity tasks, such as keyboarding, gripping, and pushing or pulling with the hands and arms, these would likely need to occur in a seated position. PQME Dr. Anderson further noted that applicant experiences significant pain that interferes with function and would require unscheduled breaks and likely result in increased absenteeism. As a result, PQME Dr. Anderson concluded that applicant would likely be unable to compete in the open labor market and would be limited to highly sedentary work that allows her to sit most of the time, take breaks as needed, and maintain a flexible schedule that permits her to come and go as her symptoms dictate. (App. Ex. 2, p. 3.)

In his supplemental report dated September 6, 2019, with respect to apportionment, PQME Dr. Anderson determined that, after reviewing additional medical records, he determined that applicant experienced lumbar radiculopathy as early as 2009, likely following a prior motor vehicle accident, which indicates the presence of underlying structural and degenerative changes in the lumbar spine before the industrial injury. Although the records from 2010 through 2014 do not document ongoing symptoms and applicant maintained functional employment during that period, the documented radiculopathy in 2009 demonstrates that degenerative processes and structural vulnerability already existed and likely contributed to the MRI findings observed in 2014. In light of this evidence, PQME Dr. Anderson concluded that the preexisting degenerative condition played a greater role in her residual disability than previously recognized. Therefore, while the industrial injury remains the primary cause of applicant's impairment and need for surgery, PQME Dr. Anderson increased the apportionment to nonindustrial degenerative factors from 10% to 20%, with the remaining 80% attributed to the March 19, 2014 industrial injury. (App. Ex. 4, pp. 32-34.)

In her report dated November 30, 2020, Dr. Feinberg, after evaluating applicant, determined that her functional capacity is limited to a semi-sedentary work level, characterized by a slow, non-competitive pace and a reliance on a single-point cane for balance (Joint Ex. 100, pp. 2-3, 10). Clinical findings reveal a chronic pain syndrome with an antalgic gait and high fall risk, though variable effort and fear-avoidance behaviors complicated the evaluation. (*Id.* at pp. 2, 7, 9.) Her specific physical restrictions include a maximum occasional lift of 10 pounds from waist to shoulder and 5 pounds from floor to waist. (*Id.* at p. 3.) Postural limitations prohibit kneeling or traversing uneven ground, while stooping, twisting, and climbing stairs are restricted to an infrequent or occasional basis. (*Id.* at pp. 3-4.) Regarding tolerances for sustained positions, she is limited to sitting for 30 minutes (maximum 5 hours daily), standing for 20 minutes, and walking for 15 minutes at a time, always requiring periodic sitting breaks to manage radiating low back and leg pain. (*Id.* at pp. 10-11.)

In his supplemental report dated August 4, 2021, PQME Dr. Anderson concluded that applicant retains limited physical capacity for sedentary or semi-sedentary activities but cannot compete in the open labor market. The FCE by Dr. Feinberg shows applicant can perform some restricted tasks, including limited sitting, standing, and lifting, but she moves at a slow, noncompetitive pace and has reduced endurance. (App. Ex. 5, pp. 4-5.) PQME Dr. Anderson

explained that chronic pain syndrome and its psychological effects further impair concentration, persistence, and reliability. (*Id.* at pp. 5-6.) These factors would likely cause decreased productivity, unscheduled breaks, and absenteeism. As a result, although applicant can perform some isolated physical activities, her overall functional limitations would prevent her from competing with other job applicants. (*Id.* at p. 6.) Her capacity for work remains limited to highly restricted sedentary activity with significant functional limitations. (*Id.* at p. 7.)

Given that applicant's expert VE Mr. Brodzinsky retired, she subsequently retained VE Mr. Diaz to provide further vocational reporting. In his report dated January 5, 2022, VE Mr. Diaz, after evaluating applicant, opined that her physical limitations prevent her from competing in the open labor market. She graduated from high school in 1970, earned "A" grades, reported no learning disabilities and can speak, read, and write English, demonstrating basic educational competency. (App. Ex. 6, p. 6.) Testing shows that she can sit for only about 30 minutes at a time, stand about 20 minutes in a 30-minute period, with a daily maximum of roughly 90 minutes, and walk about 15 minutes in a 30-minute period, also up to about 90 minutes per day. She cannot bend, squat, kneel, crawl, or walk on uneven ground, and she can lift, carry, push, or pull no more than about 10 pounds. She also exhibited chronic low back pain radiating into the right leg, impaired balance, use of a cane, and reduced endurance, all of which slowed her pace during testing and prevented her from maintaining a competitive work speed. (*Id.* at p. 7.)

VE Mr. Diaz concluded that applicant has lost all access to the labor market, effectively rendering her unemployable. He contends that, even if she retains minor physical capabilities, she cannot satisfy fundamental employer requirements such as meeting production demands, hitting deadlines, or maintaining consistent customer service. He specifically highlights that her chronic pain syndrome and "unpredictable flares" would cause excessive absenteeism and frequent productivity breaks. PQME Dr. Anderson notes that her slow movements and the psychological impact of her pain make her non-competitive against other applicants while Dr. Feinberg describes applicant's "noncompetitive work pace" and heavy reliance on a cane. Ultimately, VE Mr. Diaz asserts that no realistic occupations exist for applicant in the open labor market. (*Id.* at pp. 49-50.)

With respect to apportionment, VE Mr. Diaz attributes 100% of applicant's labor market loss to her industrial injury on March 19, 2014. He explicitly rejects any vocational apportionment to preexisting or subsequent factors, whether industrial or nonindustrial. He contends that applicant likely would have continued working in her usual and customary occupation if this specific injury

had never occurred. Consequently, he concludes that the March 19, 2014 industrial injury served as the sole cause for her total loss of access to the labor market. (*Id.* at p. 50.)

In her report dated August 15, 1999, VE Ms. Suhonmo, after evaluating applicant, concluded that she has effectively completed her work life and is retired, noting that she is not seeking a return to competitive employment. (Def. Ex. B, pp. 21, 36, 41.) VE Ms. Suhonmo supports this conclusion by determining that applicant's case does not meet the strict legal criteria for rebutting a scheduled disability rating because her inability to benefit from vocational rehabilitation is due, at least in part, to preexisting nonindustrial factors rather than being solely attributable to her March 19, 2014 industrial injury. (*Id.* at pp. 35-36.) Furthermore, VE Ms. Suhonmo highlights that applicant's residual work life expectancy is very limited at a mean of 1.01 years and that she is already receiving Social Security disability benefits and a small private retirement pension, which reinforces her status as retired. (*Id.* at pp. 18, 20-21, 36.)

In her supplemental report dated April 25, 2022, VE Ms. Suhonmo concluded that applicant, having retired from the open labor market, failed to meet the legal criteria to rebut her permanent disability rating because her industrial injury was not the sole cause of her vocational incapacity. (Def. Ex. C, pp. 2, 18.) VE Ms. Suhonmo supports this conclusion by noting that medical evidence, including a FCE by Dr. Feinberg, indicates applicant retains the physical ability to perform sedentary to light-demand work, yet she has expressed no intent to return to the workforce and is already receiving Social Security Disability and pension benefits. (*Id.* at pp. 7-8, 10.) Furthermore, VE Ms. Suhonmo emphasizes that nonindustrial factors such as preexisting degenerative disk disease and nonindustrial bilateral knee surgeries, which accounts for a substantial portion of her overall disability, influenced significantly applicant's inability to participate in vocational rehabilitation. (*Id.* at pp. 8-9.) Finally, during physical testing, applicant demonstrated "variable effort," suggesting her functional abilities may be greater than she reported, which further reinforces VE Ms. Suhonmo's opinion that applicant's lack of employment is due to retirement rather than a total loss of earning capacity caused exclusively by the industrial injury. (*Id.* at pp. 10-11.) VE Ms. Shuonmo concluded that applicant's unpredictable flares of pain would result in frequent absenteeism and productivity breaks, creating a significant barrier to gainful employment but dismissed them as subjective and difficult to measure objectively. (*Id.* at pp. 8-9.)

The parties proceeded to trial on July 26, 2022 where applicant testified, in pertinent part, that she worked as a transporter for defendant for 14 years. She sustained an industrial injury on March 19, 2014, when, while driving, another vehicle sideswiped her vehicle. She has not worked since her industrial injury. (Minutes of Hearing / Summary of Evidence (MOH/SOE, 07/26/2022, 6:24-27.) Prior to this injury, she had no work restrictions or symptoms, and she had successfully returned to work following bilateral knee replacement surgeries in 2003 and 2009. (MOH/SOE, 07/26/2022, 6:42-47.) Following her industrial injury, she underwent spinal surgery, which involved the placement of screws. (MOH/SOE, 07/26/2022, 6:29-32.) She experiences chronic back and leg pain, right-sided weakness, and sleep disturbances, for which she currently treats with Timothy Lowe, M.D. (MOH/SOE, 07/26/2022, 7:11-16.) Due to prior kidney damage from naproxen, she relies only on Tylenol to manage her symptoms. (MOH/SOE, 07/26/2022, 7:33-35.) She uses a cane prescribed in 2014 whenever she leaves her house, can only sit for up to 30 minutes at a time, and requires in-home assistance from her daughter for cooking, cleaning, and transportation, care she did not require before the accident. (MOH/SOE, 07/26/2022, 7:21-24, 7:45-57 to 8:1, 8:35-37.) She loved her job, had no interest in retiring, and her employer was unable to accommodate her with an alternative position. (MOH/SOE, 07/26/2022, 7:8-9, 8:20-21.)

Kurt Norton, a private investigator with 25 years of experience, testified on behalf of defendant to authenticate a sub-rosa surveillance video. He conducted sub-rosa on April 10 and April 13, 2019, but only obtained footage on April 13, 2019. Mr. Norton confirmed the footage was an accurate and unaltered presentation of events. (MOH/SOE, 07/26/2022, 9:7-14.) The surveillance captured applicant walking in a parking lot outside a state prison using a cane in her right hand at 10:00 a.m. (MOH/SOE, 07/26/2022, 10:18-24.) At 14:35 military time, she walked to her vehicle and opened the trunk. She was not using her cane but was using the car for balance. She then got into the driver's seat, utilizing a cell phone, and drove away. (MOH/SOE, 07/26/2022, 10:26-42.) On cross-examination, Mr. Norton stated he had already purged his handwritten notes regarding the investigation, as it had been over three years. (MOH/SOE, 07/26/2022, 9:25-30.)

Applicant was recalled for cross-examination and further testified as follows. When presented with medical records from 2009 detailing a prior motor vehicle T-bone collision, back pain, and prescriptions for Vicodin, she could not recall the accident or the treatments, though she noted that, if it is in the Kaiser Permanente records, it happened. (MOH/SOE, 07/26/2022, 11:8-21.) She also could not recall a 42-day hospitalization in 2017 for leg swelling but similarly

acknowledged the accuracy of the medical records. (MOH/SOE, 07/26/2022, 12:28-31.) Regarding the April 13, 2019 sub-rosa video, she recalled driving herself to San Quentin in April 2019, noting she stopped to rest at a service station. She testified she can drive short distances. She further testified she does not recall meeting with VE Ms. Suhono, nor does she recall telling her she was retired. (MOH/SOE, 07/26/2022, 13:8-17.) On redirect examination, applicant reiterated that she had returned to full duty after her total knee replacement and currently has no knee restrictions. She confirmed she did not seek any medical treatment from 2010 to 2014. (MOH/SOE, 07/26/2022, 13:23-28.)

On September 13, 2022, the WCJ issued her F&A, awarding applicant 51% permanent disability. The decision was based on PQME Dr. Anderson's findings of 40% WPI with 20% apportionment and rejecting the opinion of VE Mr. Diaz. The WCJ rated the permanent disability as follows:

> LUMBAR SPINE – GAIT DERANGEMENT
> 80% (17.01.07.00 - 40 - 56 - 250F - 56 - 64%) 51%
>
> It is from this F&A that applicant seeks reconsideration.

DISCUSSION

I. PERMANENT DISABILITY

Permanent disability refers to the lasting, irreversible effects of an injury. It includes conditions that impair earning capacity, limit the normal use of a body part, or create a competitive disadvantage in the labor market. Permanent disability payments compensate workers for both physical loss and the reduction, partial or total, of their future earning potential. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320 [72 Cal.Comp.Cases 565].)

In addition, while the AMA Guides function as advisory frameworks, they are not strict texts subject to rote or literal application. Instead, an evaluating physician may use their experience and expertise to interpret and apply any portion of the entire AMA Guides. Pursuant to *Almaraz/Guzman II*, the Appeals Board held that:

> [W]hile the AMA Guides often sets 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 contemplates that a

physician will use his or her judgment, experience, training, and skill in assessing WPI.

(*Almaraz/Guzman II, supra*, 74 Cal.Comp.Cases. at pp. 1103-1104; affirmed by *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837] (*Guzman III*).)

The overarching goal of rating permanent impairment is to achieve accuracy (*Guzman III*, *supra*, 187 Cal.App.4th at p. 822) and the standard for calculating WPI is to determine the most accurate reflection of impairment as measured by any chart, table, or methodology contained within the entire AMA Guides. Thus, the proper application of *Almaraz/Guzman II* requires a physician to provide a strict AMA Guides rating, explain why that strict rating does not accurately reflect the injured employee's functional limitations, and, with reasoned explanation, support an alternative rating derived from within the AMA Guides that more accurately reflects the employee's level of disability. (*Id.* at p. 828-829; *Leiva v. Webcor Construction* [2025 Cal. Wrk. Comp. P.D. LEXIS 390, *29-30]; *Linstad v. City of Richmond* [2025 Cal. Wrk. Comp. P.D. LEXIS 5, *9]; *Martin v. Cox Castle & Nicholson, LLP* [2024 Cal. Wrk. Comp. P.D. LEXIS 212, *17]; *Kelley v. Lawrence Berkeley National Laboratory* [2024 Cal. Wrk. Comp. P.D. LEXIS 115, *11].)[2]

In *Fitzpatrick*, the court also acknowledged that it is permissible to depart from the scheduled rating based on a VE opinion that an injured employee has a greater loss of future earning capacity than reflected in a scheduled rating. (*Fitzpatrick v. Workers' Comp. Appeals Bd.* (2018) 27 Cal.App.5th 607, 613-614 and 618-620 [83 Cal.Comp.Cases 1680]; see *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1274 [76 Cal.Comp.Cases 624]; *Contra Costa County v. Workers' Comp. Appeals Bd.* (*Dahl*) (2015) 240 Cal.App.4th 746, 758 [80 Cal.Comp.Cases 1119]; *LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234, 245-246 [48 Cal.Comp.Cases 587, 594] (*LeBoeuf*).)

In *LeBoeuf*, the Supreme Court applied a standard of labor market reality stating that, "A permanent disability rating should reflect as accurately as possible an injured employee's

[2] Unlike en banc decisions, panel decisions are not binding precedent on other Appeals Board panels and WCJs. (See *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) However, panel decisions are citable authority and we consider these decisions to the extent that we find their reasoning persuasive, particularly on issues of contemporaneous administrative construction of statutory language. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 242, fn. 7 (Appeals Board en banc); *Griffith v. Workers' Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1264, fn. 2 [54 Cal.Comp.Cases 145].) Here, we refer to these panel decisions because they considered a similar issue.

diminished ability to compete in the open labor market. The fact that a worker has been precluded from vocational retraining is a significant factor to be taken into account in evaluating his or her potential employability." (*Ibid.*) The court concluded, "This is to ensure that the permanent disability rating upon which an award is based accurately reflects both the permanent medical and vocational disabilities." (*Id.* at p. 243.)

To rebut the PDRS and establish permanent total disability, applicant must prove the following:

1) Applicant has received a work restriction(s), which requires substantial medical evidence.
2) The work restriction(s) precludes applicant from rehabilitation into another career field, which requires vocational expert evidence.
3) The work restriction(s) precludes applicant from competing on the open labor market, which requires vocational expert evidence.
4) The cause of the work restriction(s) is 100% industrial, which requires substantial medical evidence.

(*Valdovinos v. Universal Site Services, Inc.* [2025 Cal. Wrk. Comp. P.D. LEXIS 76, *14] (*Valdovinos*).)

Finally, the law requires the Appeals Board to base its decisions on substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) To constitute substantial evidence, a medical or vocational opinion must state its conclusions in terms of reasonable probability, avoid speculation, rely on pertinent facts and an adequate examination and history, and explain the reasoning supporting its conclusions. (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).) Medical or vocational reports and opinions do not constitute substantial evidence when they contain known errors or rely on facts that are no longer germane, inadequate medical histories or examinations, or incorrect legal theories. Likewise, a medical or vocational opinion cannot support the Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].) Accordingly, the Board may reweigh the evidence and reach a decision different from the WCJ's

determination when other evidence of substantial probative value supports a contrary conclusion. (*Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 281 [39 Cal.Comp.Cases 310]; *Garza v. Workers' Comp. Appeals Bd.* (1970) 3 Cal.2d 312, 318-319 [35 Cal.Comp.Cases 500].)

Here, upon independent review of the record, we conclude that PQME Dr. Anderson adequately addressed *Almaraz/Guzman II* with respect to the low back by providing strict WPI ratings pursuant to the DRE and ROM but ultimately finding gait derangement to be a more accurate assessment of applicant's condition and functional limitations, thereby increasing the WPI from 30% to 40%.

We also conclude that VE Mr. Diaz's opinion on permanent disability is substantial vocational evidence pursuant to *Fitzpatrick, LeBoeuf* and *Valdovinos* because it provides a detailed, individualized assessment of applicant's amenability to rehabilitation and her ability to compete in the open labor market, grounded in the medical findings of PQME Dr. Anderson and Dr. Feinberg. VE Mr. Diaz's analysis was not speculative. Rather, he meticulously integrated the physical limitations identified by PQME Dr. Anderson and Dr. Feinberg, such as applicant's inability to sit for more than 30 minutes, her non-competitive work pace, and her regular use of a cane, to conclude that she cannot meet the fundamental productivity and attendance requirements of any realistic occupation. (App. Ex. 6, pp. 7, 49). By addressing applicant's specific educational background, age, and objective physical restrictions, VE Mr. Diaz's reporting met the legal framework needed to explain how the medical disability translated into a vocationally driven total loss of earning capacity.

In contrast, VE Ms. Suhonmo's vocational reports fail to constitute substantial evidence as her opinion relies on speculation. Her conclusion that applicant has "effectively retired" lacks a grounded factual basis, as the report fails to provide a "how and why" analysis to demonstrate that her withdrawal from the workforce was voluntary rather than a direct consequence of her industrial physical limitations. VE Ms. Suhonmo's opinion on employability also fails the *LeBoeuf* standard of labor market reality by suggesting that applicant could maintain sedentary work despite medical restrictions requiring unscheduled "absenteeism" and "breaks in work productivity," accommodations which are virtually non-existent in the competitive unskilled labor market. Because VE Ms. Suhonmo improperly substitutes her own medical and credibility judgments regarding "variable effort" for the objective findings of PQME Dr. Anderson and Dr. Feinberg, the vocational opinions are logically inconsistent and legally insufficient.

II. APPORTIONMENT

Apportionment is the process utilized to segregate permanent disability or the residuals caused by an industrial injury from those attributable to other industrial injuries or to nonindustrial factors, to allocate legal responsibility fairly. (*Brodie*, *supra*, 40 Cal.4th at p. 1321; *Marsh v. Workers' Comp. Appeals Bd.* (2005) 130 Cal.App.4th 906, 911 [70 Cal.Comp.Cases 787].)

The mere fact that a medical report assigns approximate percentages of industrial and nonindustrial causation does not make the report reliable medical evidence by itself. (*E.L. Yeager Construction v. Workers' Comp. Appeals Bd.* (*Gatten*) (2006) 145 Cal.App.4th 922, 927-928 [71 Cal.Comp.Cases 1687].) Instead, apportionment of permanent disability is "based on causation" and the "employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment." (Lab. Code, §§ 4663(a) and 4664(a).) "The plain reading of 'causation' in this context is causation of the permanent disability." (*Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 611.) Apportionment now includes pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions, provided there is substantial evidence establishing that these other factors have caused permanent disability. Pursuant to *Escobedo*, a physician's opinion must rely on reasonable medical probability, cannot be speculative, must rely on pertinent facts and/or an adequate examination and history, and must set forth the reasoning in support of its conclusions. (*Id.* at p. 621.) That is, a physician must explain the "how and why" of their apportionment opinion (*Ibid.*) and consider all potential causes of disability, whether from a current, prior or subsequent industrial or nonindustrial injury or condition. (*Benson v. Permanente Med. Group* (2007) 72 Cal.Comp.Cases 1620, 1622 (Appeals Board en banc).)

The burden of proof to establish apportionment falls on defendant. (*Pullman Kellogg v. Workers' Comp. Appeals Bd.* (*Normand*) (1980) 26 Cal.3d 450, 456 [45 Cal.Comp.Cases 170]; *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1115 [71 Cal.Comp.Cases 1229].) In other words, an employee does not have the burden of disproving apportionment while defendant remains passive. (*Alcantar v. Martinez* [2025 Cal. Wrk. Comp. P.D. LEXIS 231, *9]; *Moraido v. County of San Diego* [2024 Cal. Wrk. Comp. P.D. LEXIS 375, *13, fn. 3]; *Arias v. William Roofing Co.* [2024 Cal. Wrk. Comp. P.D. LEXIS 29. *5]; *Matias v. Naturipe Berry Growers* [2024 Cal. Wrk. Comp. P.D. LEXIS 52, *4]; *Herrera v. Maple Leaf Foods* [2018 Cal. Wrk. Comp. P.D. LEXIS 430, *15].)

In reviewing the medical reports of PQME Dr. Anderson, it is clear that, while he provides an extensive clinical history and a complex rating of permanent disability, his apportionment opinions fail to meet the legal standard for substantial medical evidence. Following the March 19, 2014 industrial rear-end motor vehicle accident, applicant immediately reported neck, thoracic spine, lumbar spine, right shoulder, and right leg pain, eventually leading to a bilateral L4-L5 posterior spinal fusion and right L4-L5 transforaminal lumbar interbody fusion. (App. Ex. 1, pp. 15, 22, 32-33.) PQME Dr. Anderson ultimately determined that applicant suffered 40% WPI based on an analogous gait derangement rating under *Almaraz/Guzman II*. However, PQME Dr. Anderson's apportionment of this impairment is not legally sufficient because he failed to frame his opinion in terms of reasonable medical probability and failed to provide specific "how and why" reasoning behind his conclusion rather than speculate. In his January 10, 2018 report, PQME Dr. Anderson assigned 10% to preexisting degenerative changes simply by noting that they "play a role in . . . resulting future medical needs," an assertion that lacks any explanation of how "mild" changes contribute to the current level of impairment. (App. Ex. 1, at p. 45.) He then increased this to 20% in his September 6, 2019 supplemental report based on a 2009 record of radiculopathy, despite acknowledging that the records from 2010 through 2014 do not document ongoing symptoms and it remains unknown if she had fully recovered. (App. Ex. 4, pp. 32-34.) Attributing a percentage of disability to degenerative causes without elaboration, specifically without describing how and why the degenerative process or the industrial injury resulted in a specific portion of the current permanent disability, renders his opinion a bare conclusion. Because he failed to provide a detailed factual basis or a clear line of reasoning connecting these past findings to the current 40% WPI, his apportionment findings are speculative and do not constitute substantial medical evidence.

Accordingly, as our Decision After Reconsideration, we amend the F&A to award 100% permanent disability and defer attorney fees. We otherwise affirm the F&A.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings & Award dated September 13, 2022 is **AFFIRMED** except that it is **AMENDED** as follows:

FINDINGS OF FACT

* * *

5. Applicant's injury caused permanent disability of 100%, entitling applicant to $188.94 per week (subject to reduction for an attorney's fee) during the period April 4, 2016 to present and continuing, less monies previously paid during that period, less stipulated third-party credit and less reasonable attorney fees.

6. Attorney fees are deferred.

* * *

AWARD

AWARD IS MADE in favor of **RUBY FREEMAN** against ACE American Insurance Company, administered by Sedgwick Claims Management Services, Inc. as follows:

a. Permanent disability in accordance with Finding of Fact 5, with attorney fees deferred.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER

/s/ ANNE SCHMITZ, DEPUTY COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MARCH 19, 2026

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

RUBY FREEMAN
BOXER & GERSON, LLP
MANNING & KASS, ELLROD, RAMIREZ, TRESTER LLP

DLP/*cs*

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

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

JUANA CAMPOS, *Applicant*

vs.

STAFFCHEX, INC.; CALIFORNIA INSURANCE GUARANTEE ASSOCIATION, for LUMBERMEN'S UNDERWRITING ALLIANCE in liquidation, Defendants

Adjudication Number: ADJ9966846
Sacramento District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration to allow us time to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.[1]

Defendant seeks reconsideration of the Findings, Award and Order (FA&O) issued on January 14, 2022, by a workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant, while employed during the cumulative trauma period through September 17, 2010, as a machine assembler builder, sustained industrial injury to her neck and left shoulder and in the form of bilateral carpal tunnel and claims to have sustained industrial injury to her right shoulder and bilateral upper extremities, and found that applicant's injury caused 72% permanent disability.

Defendant contends that the WCJ erred in including 31% permanent disability for the sleep impairment as part of the permanent disability because applicant neither claimed nor identified sleep as an injured body part. Furthermore, defendant argues that no testimonial or medical evidence supports including sleep as an injured body part under a "strict"[2] application of the AMA Guides to

[1] Commissioner Lowe was on the panel that issued the order granting reconsideration. Commissioner Lowe no longer serves on the Appeals Board. A new panel member has been appointed in her place.

[2] The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, does not use the term "strict" to describe a "standard" rating. The text refers to its framework as a "standardized method" and a "standard method," (AMA Guides, pp. 4, 18.) but it deliberately avoids language that implies rigid inflexibility. Instead, the AMA Guides emphasizes that evaluating permanent impairment inherently requires the integration of "clinical judgment," which constitutes the essence of medical practice by combining both the "art" and "science" of medicine. The AMA Guides explicitly acknowledges that it cannot provide an impairment rating for all possible conditions and directs evaluating physicians to rely on their

the Evaluation of Permanent Impairment (AMA Guides) impairment rating. Defendant asserts that the sleep impairment identified by Panel Qualified Medical Evaluation (PQME) Ana Salinas, M.D., was based solely upon *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc) (*Almaraz/Guzman II*), rather than the standard application of the AMA Guides. Defendant asserts that therefore, applicant's award of permanent disability should be based upon a standard AMA Guides rating of 59% for the compensable body parts.

We have received an answer from applicant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny reconsideration.

We have considered the allegations in defendant's Petition, applicant's Answer and the contents of the WCJ's Report. Based on our review of the record, and for the reasons discussed in the WCJ's Report and as discussed below, as our Decision After Reconsideration, we amend the FA&O to award applicant 76% permanent disability (Finding of Fact 3, Award 1), to clarify that applicant is awarded reasonable and necessary medical treatment (Award 4), and otherwise affirm the decision.

BACKGROUND

The parties stipulated that applicant, while employed through September 17, 2010, as a machine assembler builder, sustained industrial injury consisting of bilateral carpal tunnel syndrome and further claims industrial injury to the neck, shoulders, and bilateral upper extremities. (Minutes of Hearing and Summary of Evidence (MOH/SOE) 11/08/2021, 2:4-8.)

The parties jointly submitted into evidence the PQME reports and depositions of Dr. Salinas. (Joint Exs. A-BBB.)

Applicant testified at the trial on November 8, 2021, as follows:

She worked for Staffchex, Inc., for approximately two years as a machine assembler builder, performing tedious labor that required lifting heavy objects all day. (MOH/SOE, 11/08/2021, 6:7-9.) While working with ATM machines, she experienced numbness in her fingers followed by pain radiating from her hands to her upper extremities. She asserted that she sustained a work-related neck injury, noting that she first felt neck pain when her fingers began to go numb. (*Id.* at 6:9-12.) She specifically testified that it was difficult for her to sleep due to this pain. (*Id.* at 7:7-8.) She stated that

experience, training, and clinical judgment to formulate an "appropriate and reproducible assessment." (AMA Guides, pp. 10-11.) Consequently, characterizing a standard rating as "strict" misrepresents the foundational philosophy of the AMA Guides, which actively balances objective, standardized data with individualized medical judgment.

her condition has progressively worsened since PQME Dr. Salinas evaluated her in 2019. Applicant reported that the pain in her wrists, arms, shoulders, and both sides of her neck is now substantially worse. (*Id.* at 7:15-17.) These symptoms significantly restrict her activities of daily living (ADLs). She can only cook for her family "very little" and does so much less than she did in 2015. (*Id.* at 7:22-25.) She further testified that she requires a long time to complete any task, must stop to rest her hands, and experiences significant pain when bathing or washing her hair. While she can still clean her house, she must do so in stages to take breaks, and she can no longer clean the bathroom, mop, or sweep. (*Id.* at 8:1-10.) Regarding the reporting of her injury, she testified that she informed her initial physicians, including Kevin Luong, M.D., that her pain extended from her hands up into her arms, shoulders, and neck. She testified that Dr. Luong declined to treat her shoulders and arms, telling her he could only focus on her wrists. (*Id.* at 6:19-23.) Although her DWC-1 Form primarily listed her hands, fingers, and wrists, she explained that she also completed a body drawing at the time of her claim where she marked the pain as extending from her neck down to her hands. (*Id.* at 6:13-15, 9:4-7.)

In her report dated February 24, 2015, PQME Dr. Salinas, after evaluating applicant in the field of physiatry, took a history that her job duties involved constant lifting, pulling, pushing, and reaching, along with highly repetitive handwork performed eight hours per day, involving assembling ATM machines. Initially experiencing finger numbness that progressed to radiating pain through her wrists, arms, and neck, she underwent bilateral carpal tunnel releases on June 15, 2011 and June 11, 2012, but reported poor outcomes characterized by persistent weakness and numbness. (Joint Ex. H, p. 2.) Clinical examination established objective factors including reduced cervical and shoulder range of motion, neurological deficits in the C7 dermatome and upper extremity regions, and muscle motor strength measured at 4-/5 on the left and 4+/5 on the right. (*Id.* at p. 5.) Diagnostic electrodiagnostic studies dated January 19, 2012 by Vinay M. Reddy, M.D., confirmed the presence of severe right carpal tunnel syndrome and mild left carpal tunnel syndrome. (*Id.* at p. 10.) PQME Dr. Salinas concluded that applicant sustained industrial injury to her cervical spine, shoulders and bilateral upper extremities. (*Id.* at p. 8.)

In her supplemental report dated May 5, 2015, PQME Dr. Salinas reviewed new diagnostic imaging for applicant regarding injuries sustained to her cervical spine, shoulders, and upper extremities. MRI scans revealed straightening of the cervical spine, a pre-disc bulge at C4-5, and a 2.0 cm cystic lesion adjacent to the trachea, which PQME Dr. Salinas noted requires further medical work-up but is likely non-industrial in nature. Regarding the left shoulder, imaging showed infraspinatus and subscapularis tendinosis, a partial-thickness labral tear, and significant bone marrow

edema in the distal clavicle that likely contributes to her symptoms. MRIs of the wrists confirmed status-post carpal tunnel release with ongoing complications, including a partial-thickness tear in the right scapholunate interosseous ligament and multiple degenerative findings in the left wrist such as triangular fibrocartilage complex distortion and a ganglion cyst. She concluded that surgery will likely be necessary for the left shoulder and both wrists and requested a re-evaluation to discuss these industrial findings and treatment options with the patient. (Joint Ex. I, pp. 2-3.)

In her report dated September 24, 2015, PQME Dr. Salinas, after reevaluating applicant, noted that applicant reported ongoing complaints involving the cervical spine, shoulders, and bilateral wrists. She reported that, since too much time had transpired before her carpal tunnel surgeries, her hands became very weak, causing cups and plates to fall out of her hands and break. (Joint Ex. J, p. 3.) She is unable to wash or groom her hair, shave her legs, or drive more than 5 to 10 minutes. (*Id.* at p. 7.) PQME Dr. Salinas opined that, for the left shoulder, applicant has infraspinatus and superior fiber subscapularis tendinosis, along with a marked bone marrow edema granulation response involving the distal clavicle that likely causes her significant symptoms. Furthermore, she noted that there either is a separation between the posterior joint capsule and posterior labrum or a partial-thickness posterior labral tear without a paralabral cyst. For the right wrist, applicant has a partial-thickness tear on the mid-carpal side of the scapholunate interosseous ligament and an extensor carpi ulnaris tear without tenosynovitis. Finally, for the left wrist, she has limited extensor carpi ulnaris central tendinosis, apparent degeneration of the scapholunate and lunoatotriquetral interosseous ligaments with possible limited partial-thickness tearing, and a somewhat prominent and tortuous palmar radial recess ganglion cyst that requires clinical correlation to determine if it is causing pressure symptoms. (*Id.* at p. 9.)

In her deposition dated January 26, 2016, PQME Dr. Salinas testified that applicant performed heavy overhead work assembling ATM machines for many years, an activity consistent with developing neck and shoulder problems and that severe compression of the median nerve can cause referred pain that travels backward up the arm and into the neck. (Joint Ex. B, pp. 12:18-20; 18:18-20, 28:7-23; 30:18-25 to 31:1-10.) PQME Dr. Salinas noted MRIs that revealed significant pathology, including a posterior labral tear and capsule separation in the left shoulder. (*Id.* at p. 33:4-9; 33:14-25 to 34:1-5.) Imaging of the wrist showed a thickening of the flexor retinaculum, which she noted was likely pressing on the median nerve and contributing to applicant's extreme weakness and pain. (*Id.* at pp. 31:11-16; 31:23-25 to 32:1-4; 43:1-2.)

In her report dated July 6, 2017, PQME Dr. Salinas, after reevaluating applicant, noted that, since her last evaluation, her pain and weakness had worsened. She needs help cooking because she

cannot chop. She has minimal use of her hands causing difficulty writing with her right hand, as it will go numb. She needs assistance from her husband and young children. (Def. Ex. K, p. 8.) PQME Dr. Salinas determined applicant reached maximum medical improvement and sustained permanent disability. For the right hand and wrist, PQME Dr. Salinas applied the standard AMA Guides to assign 18% Whole Person Impairment (WPI). She used Tables 16-10 (AMA Guides, p. 482), 16-11 (AMA Guides, p. 484), and 16-15 (AMA Guides, p. 492), finding a decreased muscle motor strength grade between 2 and 3, which resulted in a 30.15% upper extremity (UE) impairment (67% x 45%) and converted to 18% WPI via Table 16-3 (AMA Guides, p. 439). Clinically, she justified her determination based on severe median nerve compression resulting in a prolonged latency of 10 milliseconds and an estimated permanent loss of nerve use of 60% or more. (*Id.* at p. 15.)

For the left hand and wrist, she applied a standard AMA Guides rating of 7% WPI. Using the same tables, she found an 11.25% UE impairment (25% x 45%) that converted to 7% WPI via Table 16-3 (AMA Guides, p. 439). This impairment stems from persistent mild carpal tunnel syndrome, an ulnar minus variant, and triangular fibrocartilage degeneration that causes significant hand weakness. (*Id.* at pp. 15-16.)

For the left shoulder, she applied the *Almaraz/Guzman II* methodology to calculate 18% WPI. Although a standard AMA Guides rating yields 0% WPI due to normal range of motion, PQME Dr. Salinas opined this inadequately reflects the severity of the shoulder injury. She noted that repetitive work caused grinding, resulting in osteolysis of the distal clavicle, the pathological destruction and resorption of bone. Consequently, she concluded that standard range of motion figures (Figures 16-40 (AMA Guides, p. 476), 16-43 (AMA Guides, p. 477), and 16-46 (AMA Guides, p. 479) fail to capture the true extent of the impairment. Relying on the strength deficit Table 16-35 (AMA Guides, p. 510), applicant demonstrated a 30% UE impairment based on decreased muscle motor strength across multiple ranges of motion (12% flexion, 3% extension, 6% abduction, 3% adduction, 3% internal rotation, and 3% external rotation), which converts to 18% WPI via Table 16-3 (AMA Guides, p. 439). (*Id.* at p. 16.)

For the cervical spine, Dr. Salinas originally documented an *Almaraz/Guzman II* rating in her report but clarified during her deposition dated November 30, 2017, that it is actually a standard AMA Guides rating. She assigned applicant 8% WPI under DRE Category II, based on Table 15-5 (AMA Guides, p. 392), due to a chronic sprain and strain and disc desiccation. (*Id.* at p. 16; Joint Ex. C, pp. 82:25 to 83:1-4.)

In addition to the specific body parts, PQME Dr. Salinas evaluated applicant's functional and systemic impairments using the *Almaraz/Guzman II* methodology. Due to extreme weakness in the upper extremities, applicant experiences profound difficulty lifting objects or performing daily activities such as cooking. (*Id.* at p. 17.) PQME Dr. Salinas rooted this functional limitation in severe objective diagnostic findings. Serial electromyograms demonstrated profound and irreversible median nerve damage in the right hand. Applicant lost over 60% of nerve function due to prolonged compression and subsequent neural fiber death. Furthermore, diagnostic testing of the left upper extremity revealed persistent carpal tunnel syndrome combined with significant structural wrist pathology, including an ulnar minus variant, fibrocartilage degeneration, and ligamentous tearing. (*Id.* at pp. 14-15.) Relying upon this extensive objective evidence of profound bilateral weakness, PQME Dr. Salinas determined the standard rating failed to reflect the true extent of the disability. Using the hernia impairment per Class 2 under Table 6-9 (AMA Guides, p. 136), this lifting impairment warrants 19% WPI. Furthermore, applicant suffers from a sleep and arousal disorder caused by constant pain in the left shoulder, neck, and hands, which severely disrupts her sleep and decreases her overall longevity. Using a sleep and arousal disorder impairment per Class 2 under Table 13-4 (AMA Guides, p. 317), PQME Dr. Salinas assigned 20% WPI for these sleep difficulties. (*Id.* at p. 17.)

When combining impairments, she explicitly recommends applying *Athens Administrators v. Workers' Comp. Appeals Bd*. (*Kite*) (2013) 78 Cal.Comp.Cases 213 (writ denied) (*Kite*) case to add, rather than combine, the left and right hand. She justified this additive method by noting the lack of overlap between the impairments and emphasizing the necessary "synergy" between the bilateral hands to function in daily life. Because applicant's hands are profoundly weak, using the standard Combined Values Chart (CVC) would create a compressive effect that fails to represent accurately her true level of disability. (*Ibid*.)

Finally, addressing apportionment, Dr. Salinas concluded the disability is 100% industrial, as there is no evidence of pre-existing osteoarthritis or other non-industrial conditions contributing to any permanent impairment. (*Id.* at p. 19.)

In her deposition dated November 30, 2017, PQME Salinas outlined applicant's permanent disabilities as stemming from repetitive work injuries that severely affect her cervical spine, left shoulder and hands. (Joint Ex. C, pp. 67:5-11; 69:2-10; 75:18-25 to 76:1.) Regarding the upper extremities, applicant suffers from severe carpal tunnel syndrome, leaving her hands so weak that she drops items and can hardly cook. (*Id.* at p. 85:3-5.) PQME Dr. Salinas testified that carpal tunnel

surgery requires cutting a strong ligament, which permanently weakens the hand. (*Id.* at p. 79:15-23.) Because standard AMA Guides often fail to capture this level of severity, she frequently uses the *Almaraz/Guzman II* rating method to more accurately reflect the impairment. (*Id.* at p. 78:11-22). For applicant's left shoulder, the disability involves osteolysis, a pathological breakdown of the bone caused by the "grinding" nature of her repetitive work. (*Id.* at pp. 66:19-25 to 67:1-14.) Additionally, applicant's cervical spine exhibits disc desiccation from C2-C3 through C5-C6, for which PQME Dr. Salinas assigned 8% WPI rating based on a DRE Category II under standard AMA Guides (*Id.* at pp. 74:16-24; 82:25 to 83:1-13.) Crucially, PQME Dr. Salinas asserts that an analysis under *Kite* would apply to applicant's disability rating for both hands and every case given the synergy between opposable limbs. (*Id.* at pp. 84:22-25 to 86:1-12.)

In her report dated May 17, 2019, following her reevaluation of applicant, PQME Dr. Salinas stated that applicant presented with worsening carpal tunnel syndrome, noting severe pain and cramping that extends from her right wrist to her shoulder, along with neck and arm pain. This condition has severely affected her ADLs. She is unable to return to work, requires assistance with personal grooming and dressing, frequently drops objects, and wakes up every two hours due to persistent pain. (Joint Ex. BBB, p. 2.) Physical examination findings revealed decreased sensation in the median and ulnar dermatomes, bilateral medial and lateral epicondylitis, and a chronic sprain of the cervical spine. Additional diagnoses include traumatic osteolysis of the left clavicle from repetitive overuse and severe, persistent median nerve compression following a right carpal tunnel release. (*Id.* at p. 5.) PQME Dr. Salinas highlighted the extreme severity of the nerve compression, noting a highly unusual right distal latency of 10.10 and resulting Wallerian degeneration where axons have died. (*Id.* at pp. 6-7.) Concluding the evaluation, she stated that applicant will not recover further and became permanently totally disabled with no apportionment and no eligibility for vocational rehabilitation. (*Id.* at p. 8.)

On January 14, 2022, the WCJ issued her FA&O finding that applicant sustained industrial injury to her neck, and left shoulder and in the form of bilateral carpal tunnel and awarded 72% permanent disability.

It is from this FA&O that defendant seeks reconsideration.

DISCUSSION

Permanent disability refers to the lasting, irreversible effects of an injury. It includes conditions that impair earning capacity, limit the normal use of a body part, or create a competitive disadvantage

in the labor market. Permanent disability payments compensate workers for both physical loss and the reduction, partial or total, of their future earning potential. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320 [72 Cal.Comp.Cases 565].)

In addition, while the AMA Guides function as advisory frameworks, they are not strict texts subject to rote or literal application. Instead, an evaluating physician may use their experience and expertise to interpret and apply any portion of the entire AMA Guides. Pursuant to *Almaraz/Guzman II*, the Appeals Board held that:

> [W]hile the AMA Guides often sets 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 contemplates that a physician will use his or her judgment, experience, training, and skill in assessing WPI.

(*Almaraz/Guzman II, supra*, 74 Cal.Comp.Cases. at pp. 1103-1104; affirmed by *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837] (*Guzman III*).)

The overarching goal of rating permanent impairment is to achieve accuracy (*Guzman III*, *supra*, 187 Cal.App.4th at p. 822) and the standard for calculating WPI is to determine the most accurate reflection of impairment as measured by any chart, table, or methodology contained within the entire AMA Guides. Thus, the proper application of *Almaraz/Guzman II* requires a physician to provide a standard AMA Guides rating, explain why that standard rating does not accurately reflect the injured employee's functional limitations, and, with reasoned explanation, support an alternative rating derived from within the AMA Guides that more accurately reflects the employee's level of disability. (*Id.* at p. 828-829; *Leiva v. Webcor Construction* [2025 Cal. Wrk. Comp. P.D. LEXIS 390, *29-30]; *Linstad v. City of Richmond* [2025 Cal. Wrk. Comp. P.D. LEXIS 5, *9]; *Martin v. Cox Castle & Nicholson, LLP* [2024 Cal. Wrk. Comp. P.D. LEXIS 212, *17]; *Kelley v. Lawrence Berkeley National Laboratory* [2024 Cal. Wrk. Comp. P.D. LEXIS 115, *11].)[3]

[3] Unlike en banc decisions, panel decisions are not binding precedent on other Appeals Board panels and WCJs. (See *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) However, panel decisions are citable authority and we consider these decisions to the extent that we find their reasoning persuasive, particularly on issues of contemporaneous administrative construction of statutory language. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 242, fn. 7 (Appeals Board en banc); *Griffith v. Workers' Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1264, fn. 2 [54 Cal.Comp.Cases 145].) Here, we refer to these panel decisions because they considered a similar issue.

In *Department of Corrections and Rehabilitation v. Workers' Comp. Appeals Bd*. (*Fitzpatrick*) (2018) 27 Cal.App.5th 607 [83 Cal.Comp.Cases 1680] (*Fitzpatrick*), the Court of Appeal found that impairments "are generally combined" using the CVC, but the "scheduled rating [under the CVC] is not absolute" and other methodologies may be used to calculate permanent disability. (*Id.* at pp.613-614.)

For example, in *Kite*, the Appeals Board concluded that impairments resulting from a cumulative injury to the bilateral hips can be added together where substantial medical evidence supports a physician's opinion that adding impairments will result in a more accurate rating of the level of disability than the rating that results from using the CVC. (See *De La Cerda v. Martin Selko & Co*. (2017) 83 Cal.Comp.Cases 567 (writ denied) [requires following a physician's opinion as to the most accurate rating method if they provide a reasonably articulated medical basis for doing so and does not require use of the term "synergistic"].)

In *Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686 (Appeals Board en banc) (*Vigil*), the Appeals Board held that an injured employee may rebut the CVC under the PDRS and combine impairments upon establishing the impact of each impairment on ADLs. To do so, the employee must demonstrate either that the rated body parts affect separate and distinct ADLs with no overlap, or that any overlap in the affected ADLs results in an increased or amplified overall functional impact. The Appeals Board explained that medical expertise is required:

> In determining whether the application of the CVC table has been rebutted in a case, an applicant must present evidence explaining what impact applicant's impairments have had upon their ADLs. Where the medical evidence demonstrates that the impact upon the ADLs overlaps, without more, an applicant has not rebutted the CVC table. Where the *medical evidence* demonstrates that there is effectively an absence of overlap, the CVC table is rebutted, and it need not be used.

(*Id.* at p. 692, italics added.)

Our en banc decision in *Vigil* issued on June 10, 2024, after our Opinion and Order Granting Petition for Reconsideration dated March 2, 2022, and is mandatory authority on all WCJs and WCAB panels. (Cal. Code Regs., tit. 8, § 10325(a); *City of Long Beach v. Workers' Comp. Appeals Bd.* (*Garcia*) (2005) 126 Cal.App.4th 298, 316, fn. 5; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1424, fn. 6; see also Govt. Code, § 11425.60(b).)

The law requires the Appeals Board to base its decisions on substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500];

LeVesque v. Workmen's Comp. Appeals Bd. (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) To constitute substantial evidence, a medical opinion must state its conclusions in terms of reasonable probability, avoid speculation, rely on pertinent facts and an adequate examination and history, and explain the reasoning supporting its conclusions. (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).) Medical reports and opinions do not constitute substantial evidence when they contain known errors or rely on facts that are no longer germane, inadequate medical histories or examinations, or incorrect legal theories. Likewise, a medical or vocational opinion cannot support the Appeals Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].) Accordingly, the Appeals Board may reweigh the evidence and reach a decision different from the WCJ's determination when other evidence of substantial probative value supports a contrary conclusion. (*Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 281 [39 Cal.Comp.Cases 310]; *Garza v. Workers' Comp. Appeals Bd.* (1970) 3 Cal.3d 312, 318-319 [35 Cal.Comp.Cases 500].)

Finally, we further observe that a grant of reconsideration has the effect of causing "the whole subject matter [to be] reopened for further consideration and determination" (*Great Western Power Co. v. I.A.C.* (*Savercool*) (1923) 191 Cal.724, 729 [10 I.A.C. 322]) and of "[throwing] the entire record open for review." (*State Comp. Ins. Fund v. I.A.C.* (*George*) (1954) 125 Cal.App. 2d 201, 203 [19 Cal.Comp.Cases 98].) Thus, once having granted reconsideration, the Appeals Board has the full power to make new and different findings on issues presented for determination at the trial level, even with respect to issues not raised in the petition for reconsideration before it. (See Lab. Code, §§ 5907, 5908, 5908.5; see also *Gonzales v. I.A.C.* (1958) 50 Cal. 2d 360, 364 ["[t]here is no provision in chapter 7, dealing with proceedings for reconsideration and judicial review, limiting the time within which the commission may make its decision on reconsideration, and in the absence of a statutory authority limitation none will be implied."]; see generally Lab. Code, § 5803 ["The WCAB has continuing jurisdiction over its orders, decisions, and awards. . . . At any time, upon notice and after an opportunity to be heard is given to the parties in interest, the appeals board may rescind, alter, or amend any order, decision, or award, good cause appearing therefor."].)

We first address the application of the *Almaraz/Guzman II* methodology to applicant's orthopedic impairments, which necessitates three distinct analyses.

First, regarding the left shoulder, PQME Dr. Salinas properly utilized *Almaraz/Guzman II* to assign an 18% WPI based on a strength deficit. This application withstands scrutiny because relying strictly on applicant's normal shoulder range of motion would yield a 0% rating. That objective

measurement manifestly fails to capture the localized functional destruction caused by applicant's underlying condition, including the osteolysis of the distal clavicle.

Second, the standard AMA Guides ratings of 18% WPI for the right hand and 7% WPI for the left hand account only for localized nerve compression and ligamentous pathology. These measurements fail to encompass the broader loss of functional capacity and profound lifting restrictions caused by applicant's extreme bilateral weakness. While the individualized ratings address the irreversible median nerve damage and structural wrist degeneration, the synergistic impact of these injuries creates a total inability to perform tasks such as cooking or lifting pots. To capture this distinct, systemic impairment, PQME Dr. Salinas permissibly analogized these lifting restrictions to a hernia impairment of Class 2 under Table 6-9. (AMA Guides, p. 136.) This secondary application is proper because *Almaraz/Guzman II* allows a physician to derive an alternative rating from within the four corners of the AMA Guides when standard paradigms fail to reflect the full extent of disability. By clearly differentiating the localized shoulder and hand impairments from the systemic lifting restriction, PQME Dr. Salinas provides a complete measurement of the compensable injury.

Third, the 20% WPI rating assigned for a sleep and arousal disorder pursuant to Table 13-4 lacks adequate medical and legal support in this instance. While a physician generally may not rely upon an *Almaraz/Guzman II* analogy to establish permanent disability for an unpled or non-compensable body part, the express parameters of the AMA Guides govern the sleep disorder assessment. Chapter 13 provides the framework for impairments of the central and peripheral nervous system, and a standard rating under Table 13-4 (AMA Guides, p. 317) typically requires a documented, underlying neurological pathology or central nervous system disorder, such as narcolepsy, a structural brain lesion, or central sleep apnea. Evaluating physicians generally do not apply Table 13-4 to sleep disturbances manifesting merely secondary to physical pain from an orthopedic injury. Nevertheless, a physician may present a well-reasoned basis for employing Table 13-4, even in the absence of the enumerated criteria necessary for a standard rating, provided there is justification for the deviation using the foundational principles of clinical judgment set forth in Chapters 1 and 2 of the AMA Guides. Chapter 1 establishes that, because the AMA Guides cannot provide an impairment rating for all possible conditions, the physician must integrate "clinical judgment," the "art" and "science" of medicine, to formulate an "appropriate and reproducible assessment." (AMA Guides, p. 11.) Furthermore, Chapter 2 requires that a physician provide an unbiased assessment based on a thorough medical evaluation, ensuring that any impairment rating represents a permanent condition that has reached maximal medical improvement. (AMA Guides, pp. 18-19.) Because PQME Dr. Salinas

assessed sleep deprivation resulting from orthopedic discomfort with an organic neurological impairment without providing the requisite well-reasoned justification under the standards established under Chapters 1 and 2, the ensuing 20% WPI rating constitutes a misapplication of the AMA Guides.[4]

Turning to the aggregation of applicant's permanent disability, our recent *en banc* decision in *Vigil* provides the mandatory analytical framework for rebutting the CVC. As we established in *Vigil*, an employee can rebut the CVC by medical evidence demonstrating an absence of overlap in the affected ADLs or that any overlapping ADLs produce an amplified, increased overall functional impact.

During her deposition, PQME Dr. Salinas articulated a legally flawed premise, testifying that the additive method is applicable to every case due to the inherent synergy between opposable limbs. Such a universal, categorical rejection of the CVC directly contradicts the individualized, evidentiary burden we demanded in *Vigil*. Nevertheless, looking beyond her overly broad legal assertion, we find the specific evidentiary record in this matter independently satisfies the *en banc* standard. She meticulously documented applicant's extreme weakness and explicitly outlined the specific synergy required between her neck, left shoulder and bilateral hands to function, noting that the standard CVC would create a compressive effect that misrepresented her true disability. When synthesized with applicant's testimony detailing severe, compounding restrictions across multiple overlapping ADLs, such as the inability to effectively cook, bathe, or maintain basic household hygiene without severe pain and rest, the record contains the requisite substantial evidence to add the impairment values under *Vigil*. Consequently, we sustain the additive methodology based not upon PQME Dr. Salinas' broad categorization, but upon the granular, individualized functional impacts preserved in the evidentiary record.

Having eliminated the WPI for the sleep and arousal disorder, preserving the WPI for the hernia impairment analogy and adding the impairments for the left and right arm, we calculate the permanent disability strings as follows:

RIGHT-ARM – PERIPHERAL NEUROPATHY
16.01.02.02 – 18 – [4] 22 – 370J – 32 – 32
LEFT ARM – PERIPHERAL NEUROPATHY
16.01.02.02 – 07 - [4] 09 – 370J – 15 – 15
LEFT SHOULDER – OTHER
16.02.02.00 – 18 – [7] 24 – 370H – 29 – 29

[4] We note that applicant filed an amended application for adjudication of claim dated May 14, 2026, to include sleep disorder as a compensable consequence from her claim of injury to her neck and bilateral upper extremities. Our holding does not constitute a finding of no injury in the form of a sleep disorder.

CERVICAL – DRE CATEGORY II
15.01.01.00 – 08 - [5] 10 – 370G – 12 – 12
HERNIA
06.05.00.00 – 19 - [6] 25 – 370G – 28 – 28
32+15 = 47
47 C 29 C 12 C 28 = 76% permanent disability

Finally, we note that the WCJ's award of medical treatment was limited to the body parts of neck, left shoulder and bilateral carpal tunnel. Section 4600(a) provides that applicant is entitled to reasonable and necessary medical treatment to "cure or relieve the injured worker from the effects of the worker's injury." There is no limitation as to "injured body parts"; instead, sections 4600 et seq. set forth the procedures for an injured worker to request authorization for treatment from an employer. Thus, we amend the FA&O to reflect that applicant is awarded future medical treatment to cure or relieve from the effects of the industrial injury (Award 4).

Accordingly, as our Decision After Reconsideration, we amend the FA&O to find that applicant's injury caused 76% permanent disability (Finding of Fact 3, Award 1), that applicant is awarded future medical treatment to cure or relieve from the effects of the industrial injury (Award 4), and otherwise affirm the decision.

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings, Award and Order issued January 14, 2022, by the WCJ is **AFFIRMED** except that it is **AMENDED** as follows:

FINDINGS OF FACT

* * *

3. Applicant is entitled to permanent disability indemnity of 76% plus life pension.

AWARD

* * *

1. Permanent disability of 76% payable at the rate of $253.35 per week beginning June 11, 2013, for 529.25 weeks totaling $134,085.49, less credit for permanent disability advances paid, less attorney's fees, plus a life pension thereafter at the rate of $91.20 per week less attorney's fees. The parties are to obtain a commutation from the DEU to determine the exact amount of attorney fees based on 15% of the permanent disability and life pension awarded herein, to be commuted sideways from the award, and subject to 3% for future

State Average Weekly Wage increases.

* * *

4. Future medical treatment to cure or relieve from the effects of the industrial injury.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

/s/ KATHERINE A. ZALEWSKI, CHAIR

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JULY 14, 2026

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

JUANA CAMPOS
EASON & TAMBORNINI, ALC
FLOYD SKEREN MANUKIAN LANGEVIN, LLP

DLP/md

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

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

LESSIE WILLIAMS, *Applicant*

vs.

SUBSEQUENT INJURIES BENEFITS TRUST FUND, *Defendant*

Adjudication Numbers: ADJ1104751 (VNO 0515079) (MF); ADJ2006794 (VNO 0515077); ADJ2723378 (POM 0267044)
Van Nuys District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration to allow us time to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.

Applicant seeks reconsideration of the Joint Findings of Fact & Order (F&O) issued on November 17, 2022, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant, while employed as a paraeducator/teacher's assistant during the period from October 1, 1978 to March 31, 2003, sustained industrial injury to her back and knees (ADJ1104751), on February 2, 1987 to her right knee (ADJ2006794), and on May 18, 2001 to her left knee (ADJ2723378); and that she was not entitled to Subsequent Injuries Benefits Trust Fund (SIBTF) benefits.

Applicant claims that she met the minimum subsequent compensable and preexisting labor disabling permanent disability threshold under Labor Code section 4751[1] to merit entitlement to SIBTF benefits.

We did not receive an Answer from defendant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending we deny reconsideration.

We have considered the allegations in the Petition, and the contents of the WCJ's Report with respect thereto. Based on our review of the record and the reasons discussed below, as our Decision After Reconsideration, we will rescind the F&O and substitute a new F&O finding that applicant's SIBTF claim is not time-barred and deferring all other issues.

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[1] Unless otherwise stated, all further statutory references are to the Labor Code.

BACKGROUND

Applicant, while employed as a paraeducator/teacher's assistant for the Los Angeles County Office of Education (LACOE), sustained the following industrial injuries:

- On February 2, 1987 to her right knee (ADJ2006794);
- On May 18, 2001 to her left knee (ADJ2723378); and
- During the period October 1, 1978 to March 31, 2003 to her back and knees (ADJ1104751)

In his report dated June 13, 2011, Agreed Medical Evaluator (AME) Roger S. Sohn, M.D., after evaluating applicant, took a history that applicant sustained distinct work-related injuries between 1984 and 2001 while performing her usual duties, yet she maintained her employment throughout each recovery. During the period from October 1, 1978 to January 16, 2003, and beginning on February 29, 1984, she injured her back after tumbling down a stairway while attempting to restrain a rushing student. On February 2, 1987, she suffered a right knee injury after stepping onto a curb, which eventually necessitated an arthroscopic surgery in 1997 that left her with chronic pain and limited mobility. Finally, on May 18, 2001, a student's chair struck her left knee, causing immediate swelling and an antalgic gait. (Court Ex. Z2, pp. 2-3.)

With respect to permanent disability, AME Dr. Sohn concluded that applicant was unable to compete in the open labor market (*Id.* at p. 11). For the lumbar spine, AME Dr. Sohn assigned 12% whole person impairment (WPI) under DRE Lumbar Category III pursuant to Table 15-3 on page 384 of the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides). However, he departed from the DRE method and, citing *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc) (*Almaraz/Guzman II*), analogized to Figure 15-19, which provides 90% WPI for complete loss of lumbar spinal function, and opined that a 50% loss of lumbar capacity equated to 45% WPI. He supported the analogy merely stating that "[s]he has severe loss of motion and spasm." For the knees, he assigned 30% WPI to each knee under Table 17-33 on page 547 of the AMA Guides but further determined that, due to applicant's need for routine use of a walker, equivalent to two canes or two crutches under Table 17-5(g) on page 529 of the AMA Guides, each knee warranted 40% WPI. He combined the bilateral knee impairment to 64% WPI and then combined that value with the lumbar spine impairment of 45% WPI, resulting in 80% WPI. (*Id.* at pp. 11–12.)

With respect to apportionment, AME Dr. Sohn apportioned, after his correction in his supplemental report dated August 31, 2011, for the lumbar spine, 50% to the October 1, 1978 to March 31, 2003 injury and 50% to underlying degenerative disease. He apportioned as follows: for the right knee, 25% to the February 2, 1987 injury, 50% to the October 1, 1978 to March 31, 2003 injury and 30% to underlying degenerative disease; and for the left knee, 20% to the May 18, 2001 injury, 50% to the October 1, 1978 to March 31, 2003 injury and 30% to underlying degenerative disease. (*Id.* at pp. 12-13, Court Ex. X-2, p.1.)

In his December 6, 2012 deposition, AME Dr. Sohn testified that applicant's severe, chronic back pain following a failed laminectomy is the primary cause of her profound impairment, asserting that her spinal condition alone justifies a total permanent disability rating, independent of her knee injuries. (Court Ex. Z3, pp. 7:18-25 to 8:1, 34:25 to 35:1-7.) While he acknowledged her bilateral knee conditions would individually restrict her to sedentary work, he maintained that she cannot reliably sustain even an at-home or part-time job due to her overall condition (*Id.* at pp. 17:15-25 to 20:1-2, 35:5-7.) Because he considered her situation a "complex or extraordinary" case involving a "horrific condition," AME Dr. Sohn utilized an *Almaraz/Guzman II* analysis rather than strictly following the standard AMA Guides, which he argues fail to properly account for her severe pain and actual work restrictions. (*Id.* at pp. 20:11-15 to 23:1-22.) To reflect accurately her true impairment, he applied a functional loss methodology, assigning a 90% impairment to the lumbar spine and 40% to the lower extremities (*Id.* at p. 24:7-9.)

In his report dated August 29, 2011, AME Paul J. Grodan, M.D., after evaluating applicant, diagnosed her with industrially caused hypertension with associated renal insufficiency. AME Dr. Grodan restricted her from undue emotional stress and very heavy lifting. (Court Ex. X1, p. 46.) In addition, AME Dr. Grodan assessed 15% WPI based on Class 2 under Table 4-2 on page 66 of the AMA Guides, due to diastolic dysfunction of the left ventricle and 40% WPI based on Class 3 under Table 7-1 on page 146 of the AMA Guides, due to a glomerular filtration rate of 34. (*Id.* at pp. 45-46.) With respect to apportionment, applying *Benson v. Permanente Med. Group* (2007) 72 Cal.Comp.Cases 1620, 1622 (Appeals Board en banc), he deemed her cardiovascular condition inextricably intertwined with her 12 industrial injuries and was entirely industrial in origin. (*Id.* at pp. 44-45.)

In his supplemental report dated August 29, 2011, AME Dr. Grodan explained that applicant's cardiovascular disability, principally longstanding hypertension, cannot be separated

among her multiple injuries because it developed and worsened over time as a cumulative consequence of her numerous specific and continuous industrial orthopedic injuries. (Court Ex. X1, p. 3.) AME Dr. Grodan noted that chronic pain, repeated trauma, poor surgical outcomes, reduced mobility, emotional stress, and substantial weight gain resulting from those injuries materially aggravated her hypertension and overall cardiovascular status. Because these factors operated together over many years, he concluded their effects were "inextricably intertwined," making it impossible to apportion the condition to individual injuries or time periods without speculation. (*Id.* at pp. 3-4.) He further reasoned that asymptomatic nonindustrial degenerative disease did not drive her inactivity or weight gain and therefore did not materially contribute to the cardiovascular impairment, leading him to attribute the disability entirely to the industrial injury history. (*Id.* at p. 4.)

In his July 24, 2014 deposition, AME Dr. Grodan testified that applicant's hypertension related permanent disability developed progressively over time preventing precise separation among multiple injury periods, describing its impact as a continuous "continuum" rather than discrete events. (Court Ex. X2, pp. 16:22-25 to 17:1-8, 19:3-15.)

In his report dated July 19, 2011, AME Carl E. Marusak, M.D., after evaluating applicant, diagnosed her with a Depressive Disorder Not Otherwise Specified, attributed it predominantly to her orthopedic condition, assigned a Global Assessment of Functioning (GAF) of 63 or 11% WPI and apportioned 70% to the October 1, 1978 to March 31, 2003 with 30% to nonindustrial factors. (Court Ex. Y1, pp. 24-25, 28-30.)

In his September 8, 2014 deposition, AME Dr. Marusak testified that applicant's permanent psychiatric disability largely stemmed from chronic pain, functional loss, and reduced mobility caused by her orthopedic injuries, and he apportioned that disability primarily to industrial cumulative trauma rather than to isolated events. (Court Ex. Y2, pp. 8:1-25 to 10:1-2, 14:1-25 to 15:1-10.) He explained that, in his view, the most compelling cause was long-standing degeneration and osteoarthritis from repetitive injury, making precise allocation to specific incidents difficult (*Id.* at pp. 14:20-25 to 15:1-10). Ultimately, he apportioned 7.5% to the February 2, 1987 injury, 7.5% to the May 18, 2001 injury, 55% to the October 1, 1978 to March 31, 2003 injury and 30% to nonindustrial factors. (*Id.* at pp. 14:12-25 to 1-10.)

On March 9, 2018, applicant resolved her workers' compensation case-in-chief by way of a Compromise & Release (C&R) for $400,000.00. (App. Ex. 6.)

Applicant filed a timely application for SIBTF benefits dated September 5, 2011. (App. Ex. 11.)

On September 22, 2022, the parties appeared for trial seeking adjudication of applicant's entitlement to SIBTF benefits.

Applicant submitted into evidence the Qualified Medical Evaluation (QME) reports of Steven Scribner, D.C. (App. Exs. 9-10), Richard N. Shaw, M.D. (App. Ex. 7), and Sean Sterling, Ph.D. (App. Ex. 8), as well as the vocational expert reports of Susan Green, M.S. (App. Exs. 1, 3). Defendant submitted into evidence the QME report of Richard Byrne, M.D., dated April 15, 2022. (SIBTF's Ex. P.)

In his report dated June 1, 2019, QME Dr. Scribner, after evaluating applicant, took a history that she sustained numerous workplace injuries while employed by the LACOE from 1978 to 2004. A series of knee injuries, including incidents in which students struck her knees with chairs, progressively worsened her condition and ultimately required a total right knee replacement, after which Dr. Garfinkel removed her from work. She retired in August 2005. She now uses an electronic scooter and a wheeled walker as needed. She also developed hypertension after experiencing lightheadedness and dizziness. Her physician detected elevated blood pressure during evaluation and started her on medication, which she continues to take. In September 2000, she filed a claim for chest pain and heart-related conditions, and she remains unaware of its resolution. (App. Ex. 9, pp. 3-4.) Prior to her October 1, 1978 to March 31, 2003 injury, she states that her symptoms and impairments limited her ability to walk, sit, squat, lift, push, pull, climb, reach, stoop, hike, and perform many other activities of daily living, and she restricted herself to light work as a result of these limitations. (*Id.* at p. 4.)

With respect to permanent disability, QME Dr. Scribner agreed with AMEs Dr. Sohn, Dr. Grodan, and Dr. Marusak, finding 91% WPI. (*Id.* at p. 59.) QME Dr. Scribner stated as follows:

> Mrs. Williams was seen by Dr. Roger Sohn for AME for the orthopedic component of the subsequent injuries on June 13, 2011. She was awarded a total 80% WPI for her injuries to her lumbar spine and bilateral knees. Mrs. Williams was then evaluated by Dr. Paul Grodan on August 29, 2011 for AME for internal medicine injuries and she was awarded 15% WPI for her diastolic dysfunction and 40% WPI for her upper urinary tract disease. She also saw Dr. Carl Marusak for psychological evaluation, and she was awarded an 11% WPI for psychological impairment. No other SI impairments were addressed.

(*Id.* at p. 4.)

QME Dr. Scribner's medical record review outlined a comprehensive preexisting medical history for applicant. Prior to March 31, 2003, applicant's medical records documented a longstanding history of preexisting conditions, beginning with psychological issues described as a "phobia-fear of things" in 1963 and pulmonary problems that she reported experiencing since the 1970s. (*Id.* at pp. 49, 51.) Her surgical history before this date included a complete hysterectomy performed in 1999 for suspected endometriosis. (*Ibid.*) She developed hypertension in approximately 1998 and filed a related claim for chest pain and heart conditions in September 2000. (*Id.* at pp. 5, 15.) On April 1, 2003, Jay Brown, M.D., noted in an emergency department report that applicant took Lipitor to manage her cholesterol. (*Id.* at p. 5.)

Applicant suffers from a preexisting sleep and arousal disorder. QME Dr. Scribner found applicant has a sleep and arousal disorder that predated her later injuries and causes reduced daytime alertness, which interferes with some activities of daily living (ADLs) and limits her ability to work safely, particularly in physically demanding or driving occupations. QME Dr. Scribner assigns her 21% whole person impairment (WPI) based on Class 2 under Table 13-4 on page 317 of the AMA Guides, and recommended a sleep study. (*Id.* at p. 60.)

Applicant underwent a hysterectomy in 1999. QME Dr. Scribner found no labor disabling impairment but assigned her 11% WPI based on Class 1 under Table 7-10 on page 165 of the AMA Guides. (*Ibid.*)

Applicant suffers from preexisting hypothyroidism, causing symptoms such as lethargy, slowed mental processing, weakness, cold intolerance, and occasional dry skin, with myocardial insufficiency as a potential late effect. QME Dr. Scribner assigned 10% WPI based on Class 1 under Table 10-2 on page 218 of the AMA Guides because she requires ongoing therapy to maintain normal thyroid function. (*Id.* at p. 61.)

Applicant suffers from preexisting hyperparathyroidism with complications including stage 3 renal failure. QME Dr. Scribner assigned 12% WPI under Table 10-3 on page 219 of the AMA Guides because her symptoms respond well to medical therapy. (*Ibid.*)

Finally, applicant suffers from preexisting osteoporosis meriting an additional 8% WPI based on Chapter 10.10c on pages 240 to 241 of the AMA Guides due to her long standing hysterectomy. (*Id.* at pp. 61-62.)

In his report dated September 23, 2019, QME Dr. Shaw, after evaluating applicant, stated that she reported taking gabapentin 400 mg twice daily to manage chronic back pain following two

surgeries. She takes atorvastatin 40 mg daily for hypercholesterolemia at a stable dose since the mid-1990s. For longstanding hypertension, she takes metoprolol 100 mg twice daily, losartan 50 mg twice daily, and nifedipine XL 30 mg twice daily. She also takes omeprazole daily for mild hyperacidity and GERD, thyroid hormone replacement 0.25 mg daily, and alendronate 70 mg weekly for osteoporosis. In addition, she uses tramadol 50 mg up to three times daily as needed for pain and takes omega krill oil. (App. Ex. 7, p. 2.)

When she left her job in 2003, she weighed about 260 pounds after previously losing significant weight from gastric bypass surgery but later regaining much of it. She had weighed about 180 pounds when she began working and currently weighs about 330 pounds. She reports longstanding hypercholesterolemia treated with atorvastatin since 1995 without side effects, hypertension treated since the early 1990s, and stable irregular heartbeats. She has a long history of allergies and upper respiratory problems that progressed to mild-to-moderate asthma, aggravated by obesity, with shortness of breath requiring inhalers and associated with reduced oxygen saturation, and her physician recommends further pulmonary evaluation although she cannot lie flat for CT imaging. She also reports long-term antihistamine use, possible prior pulmonary testing with unknown results, and cardiology care. Functionally, she has relied on a walker since 2006 and a power wheelchair since 2012, uses the wheelchair outside the home, and ambulates short distances indoors by holding onto furniture. (*Id.* at pp. 3-4.)

Based on QME Dr. Shaw's record review, prior to 2003, applicant's medical records reveal a complex history of preexisting conditions, most prominently a longstanding struggle with severe obesity. Records indicate she weighed 223.5 pounds as early as 1985 and approximately 260 pounds by the time she stopped working in 2003, having previously undergone and regained weight following gastric bypass surgery. (*Id.* at pp. 3, 65.) This chronic obesity served as a foundational aggravating factor for her sleep and arousal issues. QME Dr. Shaw strongly suspected undiagnosed sleep apnea driven by her historical weight. (*Id.* at pp. 8-9.) These early conditions also affected her metabolic and cardiovascular systems, as she has managed her hypercholesterolemia with a stable medication dose since 1995. (*Id.* at pp. 2-3.) Her pulmonary history includes a preexisting pattern of upper respiratory congestion, allergies, and asthma requiring inhalers that traces back "many, many years" alongside historical antihistamine use. (*Id.* at p. 3.) Furthermore, she developed early signs of chronic renal failure around 1999, noted as 20 years prior to the 2019 exam, which laid the groundwork for associated conditions such as secondary hyperparathyroidism and osteoporosis noted

extensively in her chart. (*Id.* at pp. 6, 13, 80.) Although the medical record lacks explicit onset dates for her hypothyroidism and hysterectomy, these records clearly establish both as preexisting factors by her 2004 hospitalizations. (*Id.* at pp. 4, 6, 24.)

PQME Dr. Shaw identified a longstanding history of metabolic and cardiovascular disorders that predate the industrial injuries, tracing these issues back to the 1980s and 1990s. He utilized the Body Mass Index (BMI) as a primary diagnostic tool, noting that an initial BMI of 26.1 in the late 1970s already signaled an early risk for hypercholesterolemia and peripheral vascular disease. As the BMI climbed to 37.75 by 2003 and eventually 47.4, these metabolic disorders accelerated the advancement of hypertensive cardiovascular disease, resulting in end-organ damage such as cardiac enlargement and mild renal dysfunction. PQME Dr. Shaw classified the impairment between 30-49% WPI based on Class 3 under Table 4-2 on page 66 in the AMA Guides, citing the reliance on multiple medications and evidence of left ventricular thickening. (*Id.* at pp. 111-113.)

In his report dated July 21, 2019, PQME Dr. Sterling, after evaluating applicant, diagnosed her with a preexisting, labor-disabling Adjustment Disorder with Mixed Anxiety and Depressed Mood. (App. Ex. 8, p. 62.) This condition originated from the sudden death of her four-year-old sister in 1962, for whom 15-year-old applicant was the primary caregiver. (*Id.* at pp. 4-5.) The traumatic loss caused severe emotional sequelae, including intense guilt, crying spells, nightmares, irritability, and an inability to concentrate in school. (*Id.* at pp. 60-61.) This unresolved grief directly impaired her occupational functioning. Specifically, she quit her first job as a nurse's aide in a convalescent hospital at age 17 or 18 because interacting with severely ill patients triggered painful reminders of her sister's passing. (*Id.* at pp. 8, 61.) Because her emotional vulnerability, fatigue, and preoccupation with her sister's death made it difficult for her to face serious physical illnesses with equanimity, QME Dr. Sterling concluded this condition was genuinely labor disabling and had reached maximum medical improvement by 1967. (*Id.* at p. 62.) He determined she has a GAF score of 63 or 11% WPI.

In his supplemental report dated November 12, 2019, QME Dr. Scribner stated as follows:

> I agree with the findings of Dr. Shaw and his impairment ratings. ***Dr. Shaw assigned a range of 30%-49% WPI for the constellation of her internal medicine impairments. I will assign her at the high end of the rating at 45% WPI*** due to the impact that her internal medicine injuries have on her abilities to perform her normal ADLs. Her internal medicine impairments are highly labor disabling. She really cannot engage in any occupation at this point including sedentary work. For obvious reasons, she cannot perform any physical work as she is confined to an electronic scooter (wheelchair) for 90% of her waking hours. She is by any and all standards 100% disabled. She should not engage in any occupation or activities that may

> increase her blood pressure or get her excited in any way as this may exacerbate, her internal medical conditions to the point of catastrophic.

(App. Ex. 10, p. 4, emphasis added.)

QME Dr. Scribner added the 45% WPI to applicant's preexisting hypercholesterolemia, obesity and pulmonary impairment as well as QME Dr. Sterling's 11% WPI to applicant's preexisting psychological impairment. (*Id.* at pp. 5-8.)

In her report dated December 5, 2012, VE Ms. Green conducted an in-home interview and follow-up contacts. (App. Ex. 1, pp. 1-2.) She reviewed applicant's educational background and 25-year work history as a Teacher's Aide with LACOE (Id. at pp. 2–3). She also evaluated applicant's functional limitations, including reliance on a walker and power wheelchair, the need to elevate her legs, severely limited tolerance for sitting, standing, and walking, chronic pain, medication side effects, sleep disturbance, and psychiatric symptoms. (Id. at pp. 2, 6, 8.) VE Ms. Green applied computerized vocational testing and labor-market/transferable-skills analyses using MVQS and DOT classifications (*Id.* at pp. 7-9), adjusting applicant's profile to reflect medically documented restrictions that reduced her functional capacity to less than sedentary levels. The analyses showed that, although her pre-injury work potentially accessed numerous jobs, her current limitations eliminate viable occupational alternatives and leave her with no transferable skills and 0% residual employability. (*Id.* at p. 8.) VE Ms. Green also considered applicant's limited formal education, single-occupation work history, prior unsuccessful return-to-work efforts, and ongoing need for frequent medical care. (*Id.* at pp. 7–8.) Based on the totality of the medical evidence, vocational testing, occupational history, and observed limitations, VE Ms. Green concluded that applicant cannot reasonably compete in the open labor market, cannot sustain regular employment, and is not a feasible candidate for retraining or vocational rehabilitation. (*Id.* at pp. 8–9.)

At the trial on September 27, 2022, applicant testified in relevant part as follows: She began working as a teacher's assistant for the LACOE in 1978 and experienced her first knee injury in 1987, ultimately undergoing four right knee surgeries and one left knee surgery in 2003. She developed back problems in 2008, leading to surgery in 2010, and saw multiple doctors, including AME Dr. Sohn and QMEs Drs. Scribner, Sterling, and Shaw, providing accurate medical histories. (Minutes of Hearing / Summary of Evidence (MOH/SOE) 09/27/2022 6:13-21.) Before her employment with LACOE, she had high blood pressure, hypothyroidism, high cholesterol, kidney issues, and psychiatric concerns dating back to her teens, including PTSD and depression following her sister's death. (MOH/SOE, 09/27/2022, 6:22-24 to 7:1-8.) She received State Disability

Insurance and disability checks from Liberty Mutual Insurance Company. She retired receiving CalPERS in 2005, though she does not consider it disability retirement. (MOH/SOE, 09/27/2022, 7:12-22.) She sustained two notable knee injuries while working, one from a chair and one from a student, but returned to work with restrictions. (MOH/SOE, 09/27/2022, 7:22-25 to 8:1-7.) Currently, she takes eight medications for cholesterol and blood pressure, has no diabetes or migraines, and previously filed only one personal injury claim in the early 1970s after a Gemco counter fell on her foot. (MOH/SOE, 09/27/2022, 7:7-10, 12-13.)

On November 17, 2022, the WCJ issued his Joint F&O, finding applicant failed to establish her eligibility for SIBTF benefits. In his Opinion on Decision, the WCJ stated that, while the claim for benefits was not time-barred, there was insufficient evidentiary and testimonial evidence that there was any preexisting labor disabling conditions. (Opinion, pp. 5-6.)

It is from this Joint F&O that applicant seeks reconsideration.

DISCUSSION

SIBTF provides benefits to employees who establish that at the time of an industrial injury, they suffered from preexisting permanent partial disability from a prior injury, which results in greater overall permanent disability than from the subsequent injury alone. The purpose of the statute is to encourage the employment of the disabled as part of a "complete system of [workers'] compensation contemplated by our Constitution." (*Subsequent Injuries Fund v. I.A.C.* (*Patterson*) (1952) 39 Cal.2d 83, 86 [17 Cal.Comp.Cases 142]; *Ferguson v. I.A.C.* 50 Cal.2d 469, 475 [23 Cal.Comp.Cases 108]; *Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 619 (Appeals Board en banc).)

Section 4751 provides that if an employee with a preexisting permanent partial disability suffers a new compensable injury that increases their total disability beyond what the new injury alone would cause, and the combined permanent disability equals 70% or more, the employee is entitled to additional compensation for the portion of disability exceeding the last injury. This applies when the new injury alone, without adjustment for occupation or age, causes 35% or more permanent disability, or when the preexisting disability affected a limb or eye and the new injury, without adjustment for occupation or age, affects the opposite corresponding limb with at least 5% permanent disability on its own. (Lab. Code, § 4751.)

The key requirement of section 4751 is that an employee must demonstrate permanent partial disability before sustaining a subsequent industrial injury. (*Ferguson*, *supra*, 50 Cal.2d at p. 479; *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 619.)

Permanent disability is disability that causes permanent impairment of earning capacity or normal use of a member, or a competitive handicap in the open labor market. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320 [72 Cal.Comp.Cases 565]; *Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App.3d 224, 237 [43 Cal. Comp. Cases 310].) Permanent disability also includes impairment that causes loss of function of the body in whole or part. (Lab. Code, § 4751; *Franklin*, *supra*, 79 Cal.App.3d at p. 239) When determining permanent or total disability percentages, medical evaluators consider the nature of the physical injury or disfigurement, including the descriptions, measurements, and corresponding impairment percentages outlined in the AMA Guides. (Lab. Code, § 4660.)

Calculations for the 35% SIBTF eligibility threshold must exclude any apportionment. (*Todd v. Subsequent Injuries Benefits Trust Fund* (2020) 85 Cal.Comp.Cases 576, 583 (Appeals Board en banc) (*Todd*); *Bookout v. Workers' Comp. Appeals Bd.* (1976) 62 Cal.App.3d 214, 228 [41 Cal.Comp.Cases 595].)

While the AMA Guides function as advisory frameworks, they are not strict texts subject to rote or literal application. Instead, an evaluating physician may use their experience and expertise to interpret and apply any portion of the entire AMA Guides. Pursuant to *Almaraz/Guzman II*, the Appeals Board held that:

> [W]hile the AMA Guides often sets 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 contemplates that a physician will use his or her judgment, experience, training, and skill in assessing WPI.

(*Almaraz/Guzman II*, *supra*, 74 Cal.Comp.Cases. at pp. 1103-1104; affirmed by *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837] (*Guzman III*).)

The overarching goal of rating permanent impairment is to achieve accuracy (*Guzman III*, *supra*, 187 Cal.App.4th at p. 822) and the standard for calculating WPI is to determine the most accurate reflection of impairment as measured by any chart, table, or methodology contained within the entire AMA Guides. Thus, the proper application of *Almaraz/Guzman II* requires a physician to provide a

strict AMA Guides rating, explain why that strict rating does not accurately reflect the injured employee's functional limitations, and, with reasoned explanation, support an alternative rating derived from within the AMA Guides that more accurately reflects the employee's level of disability. (*Id.* at p. 828-829; *Leiva v. Webcor Construction* [2025 Cal. Wrk. Comp. P.D. LEXIS 390, *29-30]; *Linstad v. City of Richmond* [2025 Cal. Wrk. Comp. P.D. LEXIS 5, *9]; *Martin v. Cox Castle & Nicholson, LLP* [2024 Cal. Wrk. Comp. P.D. LEXIS 212, *17]; *Kelley v. Lawrence Berkeley National Laboratory* [2024 Cal. Wrk. Comp. P.D. LEXIS 115, *11].)[2]

The permanent disability or impairment existing before the industrial injury must be labor disabling, or constitute a basis for an award of permanent disability or impairment had it been industrially caused. (*Ferguson*, *supra*, 50 Cal.2d at p. 479; *Franklin*, *supra*, 79 Cal.App.3d at p. 237.) The preexisting permanent disability or impairment need not interfere with an applicant's employment at the time of the industrial injury, with or without accommodation, nor is loss of earnings required. (*Id.* at p. 238.)

The law requires the Appeals Board to base its decisions on substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) To constitute substantial evidence, a medical or vocational opinion must state its conclusions in terms of reasonable probability, avoid speculation, rely on pertinent facts and an adequate examination and history, and explain the reasoning supporting its conclusions. (*Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 621.) Medical or vocational reports and opinions do not constitute substantial evidence when they contain known errors or rely on facts that are no longer germane, inadequate medical histories or examinations, or incorrect legal theories. Likewise, a medical or vocational opinion cannot support the Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].) Accordingly, the Board may reweigh the evidence and reach a decision different from the WCJ's determination when

[2] Unlike en banc decisions, panel decisions are not binding precedent on other Appeals Board panels and WCJs. (See *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) However, panel decisions are citable authority and we consider these decisions to the extent that we find their reasoning persuasive, particularly on issues of contemporaneous administrative construction of statutory language. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 242, fn. 7 (Appeals Board en banc); *Griffith v. Workers' Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1264, fn. 2 [54 Cal.Comp.Cases 145].) Here, we refer to these panel decisions because they considered a similar issue.

other evidence of substantial probative value supports a contrary conclusion. (*Lamb*, *supra*, 11 Cal.3d at p. 281 [39 Cal.Comp.Cases 310]; *Garza*, *supra*, 3 Cal.2d at pp. 318-319.)

An employee and their employer are not required to know of the preexisting permanent disability, impairment or underlying condition, nor must medical evidence of the permanent disability, impairment or underlying condition exist before the industrial injury. (*Subsequent Injuries Fund v. I.A.C.* (*Allen*) (1961) 56 Cal.2d 842 [26 Cal.Comp.Cases 220] [Applicant eligible for benefits under section 4751 even though preexisting hearing disability unknown and reported by otologists after industrial injury which increased disability]; *Franklin*, *supra*, 79 Cal.App.3d at p. 237 [The preexisting permanent disability or impairment may be industrial or nonindustrial, or arise from any source, developmental, pathological, or traumatic]; *Escobedo*, *supra,* 70 Cal.Comp.Cases at pp. 614-621 [Apportionment of permanent disability under SB 899 applies to pending litigation, including permanent disability which could not be previously apportioned such as a retroactive prophylactic work preclusion, if support by substantial evidence].)

However, a retroactive prophylactic work restriction determined after the industrial injury does not establish permanent disability or impairment before the injury unless substantial evidence demonstrates that the employee had work restrictions beforehand. (*Franklin*, *supra*, 79 Cal.App.3d at p. 238; *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 619.) Such evidence may include an actual prophylactic work restriction before the industrial injury. (*Franklin*, *supra*, 79 Cal.App.3d at p. 238.) Applying a retroactive prophylactic work restriction which is not supported by substantial evidence creates a factual or legal fiction of an otherwise nonexistent previously disability or physical impairment. (*Ibid.*) Instead, there must be substantial medical evidence establishing permanent disability or impairment independent of any retroactive prophylactic work restrictions. (*Allen*, *supra*, 56 Cal.2d at p. 846; *Franklin*, *supra*, 79 Cal.App.3d at p. 391.)

Here, the evidentiary record demonstrates substantial and documented preexisting impairment. For example, QME Dr. Sterling diagnosed a preexisting Adjustment Disorder stemming from a 1962 trauma that reached maximum medical improvement by 1967 and directly impaired her occupational functioning, causing her to quit a job as a nurse's aide. Additionally, QMEs Dr. Shaw and Dr. Scribner reviewed extensive medical records documenting a longstanding history of metabolic, cardiovascular, and pulmonary disorders, including severe obesity, hypercholesterolemia treated since 1995, and hypertension dating to the early 1990s, all of which predated her departure from work in 2005. Furthermore, applicant credibly testified at trial that she suffered from high blood

pressure, hypothyroidism, high cholesterol, kidney issues, and psychiatric concerns well before her employment with LACOE even began in 1978. Because the QMEs based their comprehensive evaluations firmly on historical medical records and applicant's corroborating testimony rather than on mere speculation, she has successfully established some preexisting, labor disabling conditions. Therefore, upon remand, the WCJ will need to calculate applicant's WPI based on the parts of body with documented preexisting labor disabling conditions.

In addition, AME Dr. Sohn's permanent disability evaluation fails to constitute substantial medical evidence because he explicitly abandons the mandatory, objective protocols of the AMA Guides in favor of unsupported categorizations. Regarding the lumbar spine, AME Dr. Sohn assigns 12% WPI under DRE Lumbar Category III. However, his own clinical examination directly contradicts the criteria for this category by documenting negative bilateral straight leg raising tests, symmetric deep tendon reflexes, and entirely normal lower extremity sensory findings, thereby failing to establish the requisite objective evidence of radiculopathy. In the absence of a properly supported standard rating under the AMA Guides, it is premature to apply *Almaraz/Guzman II* to support an analogous WPI approach multiplying a subjective 50% loss of overall lumbar capacity against the 90% maximum impairment delineated in Figure 15-19 for complete spinal functional loss.

Similarly, the bilateral knee evaluation lacks legal sufficiency. AME Dr. Sohn summarily concluded the total knee arthroplasties represent a "poor result" warranting 30% WPI per knee under Table 17-33 without performing the prerequisite point-based calculations for pain, range of motion, stability, and alignment required to substantiate that classification. He subsequently abandoned this unsupported rating entirely, improperly pivoting to Table 17-5(g) to extract 40% WPI per knee based exclusively on applicant's use of a walker. Because Dr. Sohn failed to articulate any clinical rationale explaining how the walker usage independently satisfies the rigorous functional criteria of Table 17-5 or why it justified overriding the specific joint replacement protocols of Table 17-33, his ultimate impairment conclusions lack the indispensable analytical integrity necessary to support a judicial finding of permanent disability. Accordingly, because AME Dr. Sohn's WPI rating does not comply with the AMA Guides, his opinion does not constitute substantial medical evidence.

We also find problematic QME Dr. Scribner's attempt, in his analysis, to exact a 45% WPI rating from QME Dr. Shaw's 30-49% WPI for the hypertensive cardiovascular disease, a determination that traverses outside of QME Dr. Scribner's expertise in chiropractic medicine.

In addition, given that we found AME Dr. Sohn's opinion on permanent disability not substantial medicine evidence, we are unable to rely on QME Dr. Scribner's mere adoption of the opinion as his own substantial medical evidence. Finally, his chiropractic assessment of permanent disability for the hypothyroidism, hyperparathyroidism and osteoporosis, conditions more suited for opinion by a physician skilled in internal medicine, cannot form the basis of reliable medical evidence for a judicial determination of preexisting labor disabling permanent disability.

"[I]n order to ensure reliance on substantial evidence, and a complete adjudication of the issues consistent with due process," the WCJ and the Appeals Board both have a duty to further develop the record where there is an absence of, or insufficient evidence to determine the issues raised for trial. (*Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal. App.4th 389, 393-395 [62 Cal.Comp.Cases 924] (*Tyler*); *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117, 1121-1122 [63 Cal.Comp.Cases 261]; see Lab. Code, §§ 5701 and 5906; *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2001) 67 Cal.Comp.Cases 138, 139 (Appeals Board en banc).) Indeed, the Appeals Board has a constitutional mandate to "ensure substantial justice in all cases," and is therefore "clearly permitted" to admit evidence even after the discovery cut-off under section 5502(d)(3). (*Kuykendall v. Workers' Comp. Appeals Bd.* (2000) 79 Cal.App.4th 396, 403-405 [65 Cal.Comp.Cases 264].) "[A]llowing full development of the evidentiary record to enable a complete adjudication of the issues is consistent with due process in connection with workers' compensation claims" and militates in favor of our presuming the continued vitality of sections 5701 and 5906, absent a clear legislative intention to the contrary. (*Tyler*, *supra*, 56 Cal.App.4th at p. 394.) An adequately developed record affords all parties due process of law and further provides for meaningful review by the Appeals Board of a WCJ's decision. (*Evans v. Workers' Comp. Appeals Bd.* (1968) 68 Cal.2d 753, 755 [33 Cal.Comp.Cases 350]; *Hernandez v. Staff Leasing* (2011) [76 Cal.Comp.Cases 343, 346-347] (Appeals Board significant panel decision).)

Pursuant to sections 5701 and 5906, a WCJ or the Appeals Board may not leave undeveloped issues that, through the exercise of its specialized knowledge, recognizes as requiring further evidentiary development. (*Kuykendall*, *supra*, 79 Cal.App.4th at p. 404.)

Accordingly, upon remand, we recommend that QMEs Dr. Scribner and Dr. Shaw perform reevaluations and provide independently determined permanent disability opinions for conditions within their expertise.

In addition, while we express no opinion on AME Dr. Grodan's determination that applicant's 12 industrial injuries are "inextricably intertwined," we would suggest AME Dr. Grodan issue a supplemental report reconciling his opinion with the other reporting physicians whose opinions on apportionment limit the permanent disability to 3 of the 12 injuries.

Accordingly, we rescind the F&O and substitute a new F&O finding that applicant's SIBTF claim is not time-barred and is deferred.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings & Award dated November 17, 2022 is **RESCINDED** and the following is **SUBSTITUTED** therefor:

FINDINGS OF FACT

1. Lessie Williams, while employed during the period October 1, 1978 to March 31, 2003, as a paraeducator/teacher's assistant, Occupational Group No. 214, at Los Angeles, California, by L.A. County Department of Education, sustained injury arising out of and in the course of employment to her back and knees.

2. Lessie Williams, while employed on February 2, 1987, as a paraeducator/teacher's assistant, Occupational Group No. 214, at Los Angeles, California, by L.A. County Department of Education, sustained injury arising out of and in the course of employment to her back and knees.

3. Lessie Williams, while employed on May 18, 2001, as a paraeducator/teacher's assistant, Occupational Group No. 214, at Los Angeles, California, by L.A. County Department of Education, sustained injury arising out of and in the course of employment to her back and knees.

4. Applicant's claim for Subsequent Injuries Benefits Trust Fund benefits is not time-barred.

5. All other issues are deferred.

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG L. SNELLINGS, COMMISSIONER

I CONCUR,



/s/ JOSÉ H. RAZO, COMMISSIONER

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

July 17, 2026

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

LESSIE WILLIAMS
TERRELL FIRM
OFFICE OF THE DIRECTOR – LEGAL UNIT (LOS ANGELES)

DLP/md

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

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

NERISSA WATSON, *Applicant*

vs.

COUNTY OF LOS ANGELES, permissibly self-insured, administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., *Defendants*

Adjudication Numbers: ADJ8545914; ADJ9694061
Marina Del Rey District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration to allow us time to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.

Defendant seeks reconsideration[1] of the Second Amended Findings and Award (F&A) issued on June 3, 2024. The workers' compensation administrative law judge (WCJ) found that applicant, while employed by defendant as a Detention Services Officer during the period of October 1, 2009 to January 1, 2012, sustained injury arising out of and in the course of her employment (AOE/COE) to her right wrist, right hand, left knee, heart, lungs, psyche, headaches, and gastrointestinal system, resulting in 100% permanent disability.

Defendant contends that the WCJ erred and acted in excess of her powers by failing to apply apportionment correctly pursuant to Labor Code sections 4663 and 4664.[2] Furthermore, defendant asserts it was denied its due process right to conduct discovery, specifically the right to cross-examine the Agreed Medical Evaluators (AME) on all issues, particularly regarding apportionment in accordance with *Benson v. Permanente Med. Group* (2007) 72 Cal.Comp.Cases 1620, 1622 (Appeals Board en banc) (*Benson*).

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[1] Defendant's petition for reconsideration included ADJ8545914 in its caption referencing an industrial injury during the period October 1, 2008 to October 1, 2009 to the right hand and fingers, left knee, heart, skin and immune system (in the form of a staph infection). However, the parties resolved that case by stipulations with request for award on July 13, 2015 and the WCJ's Second Amended F&A did not adjudicate any issues relating to that case. Consequently, in the absence of any decision defendant can claim to be aggrieved by, we will limit the scope of our review to ADJ9694061.

[2] Unless otherwise stated, all further statutory references are to the Labor Code.

Defendant further claims that the vocational rehabilitation reports of Enrique Vega, M.A., do not constitute substantial vocational or medical evidence because they fail to comply with *Nunes v. State of California, Dept. of Motor Vehicles* (2023) 88 Cal.Comp.Cases 741 (Appeals Board en banc) (*Nunes I*) and do not establish a successful rebuttal of the Permanent Disability Rating Schedule (PDRS) pursuant to *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1277 [76 Cal.Comp.Cases 624].

Finally, defendant contends that the Appeals Board has a duty under these circumstances to develop the record further to achieve substantial justice.

We have received an Answer to the Petition for Reconsideration from applicant, and the WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny defendant's petition.

We have considered the allegations in the Petition and the Answer, as well as the contents of the WCJ's Report. Based on our review of the record, and for the reasons discussed below, as our Decision After Reconsideration we will rescind the WCJ's decision and substitute a new decision deferring issues related to permanent disability and attorney fees. We otherwise make no substantive changes to the decision.

BACKGROUND

I.

Applicant, while employed as a detention services officer with defendant during the period October 1, 2009 to January 1, 2011, sustained industrial injury AOE/COE to her right wrist, right hand, left knee, heart, lungs, psyche, headaches, and gastrointestinal system (ADJ9694061). (Minutes of Hearing and Summary of Evidence (MOH/SOE), 03/06/2019, 2:5-9.)

On January 25, 2010, the parties executed stipulations with request for award in ADJ2576517 (LBO 0375669) in which they stipulated that applicant, on December 25, 2005, sustained industrial injury AOE/COE to her left knee resulting in 24% permanent disability based on the opinion of AME Stephen Wertheimer, M.D., with an Award dated February 10, 2010.

On July 13, 2015, the parties executed stipulations with request for award for ADJ8545914 wherein applicant, during the period October 1, 2008 to October 1, 2009, sustained industrial injury to her right hand, right wrist, left knee, heart and lungs resulting in 49% permanent disability with

dismissal of the petition to reopen for ADJ2576517 (LBO 0375669), based on the opinions of AME Dr. Wertheimer and AME Mark Hyman, M.D., with an Award concurrently issued.

The parties concurrently executed stipulations with request for award in ADJ9694061 wherein applicant they stipulated that applicant sustained injury AOE/COE to the same parts of body during the period January 1, 2010 to January 1, 2011 resulting in 6% permanent disability based on the opinions of AME Dr. Wertheimer and AME Dr. Hyman, with an Award concurrently issued. On August 31, 2015, applicant filed a timely petition to reopen ADJ9694061, alleging she sustained new and further temporary and/or permanent disability and need for further medical treatment.

Thereafter the matter proceeded to trial, scheduled for March 6, 2019. At that time, the parties amended the date of injury to October 1, 2009 to January 1, 2011 and proceeded to trial on, among other issues, parts of body injured, permanent disability and apportionment. (MOH/SOE, 03/06/2019, 2:5-6, 2:22-24.)

The parties jointly submitted into evidence the AME reports of Howard Greils, M.D. (Court Exs. X1-X3), Mark Hyman, M.D. (Court Exs. Y1-Y6), and Stephen Wertheimer, M.D. (Court Exs. Z1-Z13.) Applicant submitted into evidence the vocational expert reports of Mr. Vega. (App. Exs. 2, 6.)

At trial, applicant testified in pertinent part as follows:

She stated that she had knee surgery in 2005 or 2006 for a torn meniscus, followed by two revision surgeries and cortisone injections. (MOH/SOE, 03/06/2019, 4:21-24.) She subsequently underwent three surgeries at the University of Southern California, including a debridement, and developed sepsis in 2011 that necessitated open-heart surgery. (MOH/SOE, 03/06/2019, 4:25 to 5:1.) During that operation her heart stopped, requiring a temporary pacemaker and a seven-day stay in the intensive care unit, followed by the implantation of a permanent pacemaker for the upper and lower heart. She later underwent additional knee surgery to inspect for infection, a knee replacement in 2011, and experienced a subsequent post-replacement infection. (MOH/SOE, 03/06/2019, 5:2-5.)

Regarding her current physical and gastrointestinal condition, during the 30 days prior to the hearing she suffered severe monthly migraines accompanied by vomiting, light sensitivity, and medication use, as well as persistent headaches and chest issues and a paralyzed hand due to nerve damage. (MOH/SOE, 03/06/2019, 5:6-9.) She described stomach problems including vomiting and inability to eat, which on one occasion caused a 30-pound weight loss. (MOH/SOE, 03/06/2019, 5:8-10.) Regarding her lower extremities, her left knee hurts constantly, requiring Norco and Motrin, her right knee aches, she walks with a limp, and her left foot and ankle swell. (MOH/SOE,

03/06/2019, 5:10-12.) She also stated that cold temperatures prevent her from moving due to bodily pain. (MOH/SOE, 03/06/2019, 5:13-14.)

She suffers from depression, frequent crying, and an inability to get out of bed or shower. (MOH/SOE, 03/06/2019, 5:12-14.) She experiences severe sleep disruption and nightmares linked to her extended intensive care unit stay. (MOH/SOE, 03/06/2019, 5:19-20.) She experiences weekly panic attacks during which her hands sweat, she shakes, and her elevated heart rate causes her pacemaker to shock her. (MOH/SOE, 03/06/2019, 5:15-16.) To manage these attacks, she takes Xanax, lies down, and completely isolates herself from other people. (MOH/SOE, 03/06/2019, 5:16.) She experienced a panic attack in the parking lot on the day of the hearing and another during her testimony. (MOH/SOE, 03/06/2019, 5:17-18.)

Her initial knee pain began in 2005 and worsened due to surgery and restraints. (MOH/SOE, 03/06/2019, 5:22-23.) She had three prior workers' compensation cases, noting that a left knee injury settled for 24% permanent disability, another case settled for 49% permanent disability, and the injury subject to the current proceeding settled for 6% permanent disability. (MOH/SOE, 03/06/2019, 5:23-25 to 6:1.) She acknowledged background personal stressors noted in medical reports, including a 2010 suicide attempt, a 2011 bankruptcy, loss of her home in 2013, and her husband's job loss in 2015, agreeing that these events and related treatment occurred prior to the August 2015 settlement. (MOH/SOE, 03/06/2019, 6:2-7.)

The matter was thereafter submitted for decision, and the WCJ issued several findings and orders to develop the medical record. On November 2, 2023, the WCJ issued an F&O ordering supplemental reporting from AME Dr. Wertheimer with a complete *Benson, supra,* analysis, and applicant's counsel sought removal. On January 23, 2024, we issued an Opinion and Order Granting Reconsideration and Decision after Reconsideration (Opinion) in which we concluded that:

> [T]he order to develop the record with respect to apportionment will result in irreparable harm to applicant. The Appeals Board does not have a duty to develop the record where a party who has the burden of proof recognizes the insufficiency of the record and does not take appropriate action. (*Lozano v. Workers' Comp. Appeals Bd.* (2002) 67 Cal.Comp.Cases 970 [2002 Cal. Wrk. Comp. LEXIS 1420] (writ den.).)

(Opinion, p. 7.)

Thereafter, the matter was returned to the trial calendar on February 29, 2024, at which time the case was submitted for decision. An initial F&A issued on May 16, 2024, which was thereafter twice amended by the WCJ.

On June 3, 2024, the WCJ issued her Second Amended F&A, awarding applicant 100% permanent disability. In her Opinion on Decision, she relied on the AMEs and Mr. Vega. (Opinion on Decision, p. 3.)

In her Report, the WCJ stated the following:

In the case at bar, Dr. Howard Greils addressed **Benson** as follows:

> "This examiner cannot with reasonable medical probability, parcel out the approximate percentages to which each distinctive industrial injury causally contributed to Ms. Watson's overall permanent disability on a psychiatric basis therefor, I will state that I am able to make an apportionment determination and that determination is as follows: Approximate percentage of disability caused by each of the relevant issues in this case cannot reasonably be determined … There is a synergistic effect between the two or more injuries which does not allow permanent disability from one to be separated from the permanent disability from the others (i.e. the overall disability is greater than simply the sum of the injuries, such that each part cannot be reasonably evaluated separately)." (Exhibit X1).

> All three AMEs opined that the injuries are "inexplicably intertwined". The AMEs are unable to apply **Benson** which justifies a joint award. (**Grumman Assistance Corporation v. WCAB (Dileva) (2015) 80 CCC 749**). Petitioner failed to cross-examine the AMEs or ask the WCJ to appoint a regular doctor.

(Report, p. 5.)

It is from this Second Amended F&A that defendant seeks reconsideration.

II.

Applicant was treated and evaluated extensively for her industrial injury claim, and the following relevant medical information was noted:

On April 12, 2007, AME Dr. Wertheimer evaluated applicant, who was six weeks post arthroscopic surgery on the left knee. (Court Ex. Z8, p. 6.) She presented with subjective complaints of constant pain in both knees, attributing the right knee pain to overcompensating for the injured left knee. (*Id.* at pp. 1-2.) She reported frequent giving way and swelling of the left knee, along with significant difficulties performing daily activities such as climbing stairs, kneeling, walking long distances, and getting down on the floor. (*Id.* at pp. 3-4.) During the physical examination, AME Dr. Wertheimer observed an antalgic gait on the left side and an inability to squat due to anterolateral discomfort of the left knee. (*Id.* at p. 5.) Range of motion (ROM) in the left knee was

restricted to 0° to 100°, accompanied by a loud clunk, a grinding sensation, positive patellar grinding signs, positive apprehension, and medial joint line tenderness. Right knee ROM was 0° to 140° without pain. Roentgenograms of the left knee revealed lateral joint space narrowing, a large osteophyte on the lateral femoral condyle, and at least four loose bodies, while the right knee showed a lateral bias of the patella. AME Dr. Wertheimer diagnosed a subluxing patella with multiple loose bodies in the left knee and a subluxing right patella. (*Id.* at p. 6.)

On March 12, 2008, following a review of the submitted medical file, AME Dr. Wertheimer issued a report reiterating that the condition of applicant had remained unstable during the prior evaluation and that she needed surgery for her subluxing patella. (Court Ex. Z7, p. 5.)

On May 6, 2008, AME Dr. Wertheimer reexamined applicant. On March 28, 2008, applicant sustained a subsequent incident at work when she slipped on debris on a staircase, twisting her low back and landing on her left side, exacerbating her left knee and lower back pain. (Court Ex. Z6, p. 2.) She reported that her constant left knee pain remained her worst complaint that worsened her occasional right knee pain and introduced new low back symptoms following the recent slip and fall. (*Id*. at pp. 3-4.) The examination demonstrated lumbar flexion of 69°, extension of 26°, and left lateral bending of 36° and right lateral bending of 38°, yielding 0% whole person impairment (WPI) for the lumbar spine. (AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), Table 15-9, p. 409.) (*Id.* at pp. 8-9.) Left knee ROM was 0° to 120° with pain. (*Id.* at p. 9.) Diagnostic imaging of the left knee showed a 0 mm joint interval upon weight bearing. (*Id.* at p. 10.) AME Dr. Wertheimer determined the March 28, 2008 injury aggravated the left knee and introduced back pain. (*Id.* at p. 11.) AME Dr. Wertheimer advised the use of an unloading brace and a cane to delay the need for a total knee replacement due to the young age of applicant. (*Id.* at pp. 12-13.)

On October 6, 2009, AME Dr. Wertheimer reexamined applicant, who reported significant improvement, a 40-pound weight loss, and mostly resolved low back pain. (Court Ex. Z5, pp. 2-3. 12.) In July 2009, she gave birth to a daughter. (*Id.* at p. 2.) In September 2009, she returned to full time regular duty as a detention service officer, performing her job duties without physical altercations. (*Id.* at pp. 2, 12.) AME Dr. Wertheimer noted a normal heel to toe gait and bilateral knee ROM of 0° to 125°. (*Id.* at p. 11.) He concluded applicant had reached maximum medical improvement. Relying on the 0 mm joint interval observed on full weight bearing imaging, he assigned 20% WPI impairment rating for the left knee traumatic arthritis. (AMA Guides, Table 17-31, p. 544.) AME Dr. Wertheimer precluded applicant from kneeling, crawling, and

running. (*Id.* at p. 15.) AME Dr. Wertheimer opined that the permanent disability was entirely industrial in nature, representing cumulative trauma induced traumatic arthritis. (*Id.* at p. 16.)

On January 8, 2013, he reexamined applicant five weeks postpartum after the birth of her son for complaints including left knee pain, intermittent right knee pain, occasional low back pain, and a notable loss of right hand and finger dexterity. (Joint Ex. Z4, pp. 1-2, 11.) On January 5, 2011, she ceased working due to the onset of severe septicemia. (*Id.* at pp. 2, 11, 13.) This medical emergency developed after multiple steroid injections introduced a Staphylococcal infection into the left knee. (*Id.* at pp. 3, 13.) The infection progressed to systemic septicemia and endocarditis, which required emergency open-heart surgery for a tricuspid valve replacement on February 6, 2011 and the insertion of a pacemaker on February 14, 2011. (*Id.* at pp. 3, 11, 13.) During the cardiac surgery, she suffered prolonged nerve compression on the operating table, resulting in right hand muscle paralysis and a right wrist ulnar nerve palsy. (*Id.* at pp. 11, 13.)

For the left knee total replacement, AME Dr. Wertheimer assessed 30 points for mild pain with walking and standing, 22 points for ROM, and 25 points for stability, resulting in a total of 77 points. This score yields a "fair" result, equating to 20% WPI for the left knee. (AMA Guides, Table 17-33, p. 547; Table 17-35, p. 549.) (*Id.* at p. 14).

For the right upper extremity ulnar nerve lesion at the elbow, he assigned a 60% severity factor to both the sensory and motor deficits (AMA Guides, Table 13-23, p. 346). He applied this severity factor to the applicable maximum values for the ulnar nerve and then combined the resulting sensory and motor components to calculate 25% upper extremity (UE) impairment (AMA Guides, Table 16-15, p. 492). He then converted the 25% UE impairment to 15% WPI (AMA Guides, Table 16-3, p. 439). (*Id.* at pp. 14-15.)

Using the combined values chart (CVC), the 20% WPI for the left knee and 15% WPI for complications from her open-heart surgery combine to produce 32% WPI orthopedically. (AMA Guides, p. 604.) (*Id.* at p. 15.)

On January 7, 2014, AME Dr. Wertheimer testified in a deposition regarding the medical cascade. He explained that the original left knee injuries caused a chronic inflammatory process, which necessitated the treatment that led to the severe infections. (Court Ex. Z12, p. 12:13-24.) In his deposition dated January 26, 2023, he further testified that the prolonged bedridden state caused muscle deterioration, scar tissue formation, and loss of ROM causing gait derangement and further affected the arthritic knee. (Court Ex. Z10, pp. 8:25 to 10:1-9.)

On March 8, 2014, a medical reexamination documented constant left knee soreness that varies in intensity, intermittent right knee pain, and constant low back pain radiating to the left buttock, leg, and foot. Applicant additionally reports a loss of right hand and finger dexterity, alongside an inability to open fully the right hand, with her worst complaints being the low back and left knee pain. (Court Ex. Z3, pp. 1-2.)

On September 23, 2014, AME Dr. Wertheimer provided further deposition testimony establishing two distinct periods of cumulative trauma. He identified the first period as commencing in September 2005 and ending in September 2009 when applicant returned to regular duty. He identified the second period as beginning in October 2009 and ending in January 2011 when applicant ceased working due to the septicemia. (Court Ex. Z13, pp. 37:22-25 to 38:1-8; 38:15-25 to 39:1-2.) He apportioned 90% of the permanent disability for the left knee and right wrist to the first period of continuous trauma, and the remaining 10% to the second period. (*Id.* at pp. 39:3-18 to 40:1-24; 52:8-19.)

On January 19, 2016, he evaluated applicant who presented with subjective complaints of a loss of right hand and finger dexterity, an inability to open her right hand completely, and intermittent low back pain radiating into the left buttock and down the posterior left lower extremity. (Court Ex. Z1, p.1.) She additionally described frequent right knee aching pain and constant left knee pain that extended up her posterior left leg to her back. (*Id.* at p. 2.) She reported experiencing significant depression, spending entire weekends in bed, and crying during the evaluation. (*Id.* at pp. 3, 6, 12, 14.) AME Dr. Wertheimer examination of the upper extremities revealed the right hand postured in a clenched position, though applicant could relax her fingers upon command, and wrist dorsiflexion measured 80° bilaterally against an estimated normal of 60°. (*Id.* at p. 8-9.) Jamar dynamometer grip strength testing yielded 27, 24, and 22 kg of force on the right major hand, and 27, 29, and 29 kg on the left. (*Id.* at p. 11.) Objective evaluation of the lumbar spine demonstrated no scoliosis, kyphosis, or tenderness, with a negative straight leg raise at 90° bilaterally. (*Id.* at pp. 9-10.) Evaluation of the lower extremities showed a 0° to 120° ROM in the right knee and a 0° to 95° range in the left knee, alongside left medial collateral ligament laxity, positive right patellar grinding, and anserine tenderness on the right. (*Id.* at pp. 10-11.) Diagnostic imaging revealed a small loose body at the right radiocarpal joint, loose bodies and a total joint replacement with bone cement in the left knee, and a lateral bias of the right patella. AME Dr. Wertheimer subsequently diagnosed applicant with a status post left knee arthroscopy with a subluxing patella, multiple left knee loose bodies, a right knee subluxating patella, post staph septicemia, a status post cardiac valve surgery for

endocarditis, a right ulnar nerve palsy, a septic left knee followed by a total joint replacement, and depression. (*Id.* at p. 12.) AME Dr. Wertheimer measured lumbar flexion at 65°, representing 108% of normal spinal flexion. Utilizing a sacral flexion angle of 45° or above yielded 0% WPI. He measured lumbar extension at 22° to find 2% WPI. (AMA Guides, Table 15-8, p. 407.) Left lateral bending measured 26°, representing 104% of normal and right lateral bending measured 28°, representing 112% of normal, yielding 0% WPI for each. (AMA Guides, Table 15-9, p. 409.) He concluded that applicant sustained 2% WPI total lumbar region ROM. (*Id.* at p. 10.) Furthermore, he referenced his prior January 8, 2013 evaluation, reiterating 20% WPI for a fair result from the left total knee replacement and 15% WPI caused by septicemia, producing a combined 32% WPI orthopedic impairment. (Joint Ex. Z4, p. 14; Court Ex. Z1, p. 14.)

He noted the left knee Staph infection and ensuing septicemia possibly resulted from multiple steroid injections administered to the left knee, which ultimately necessitated open-heart surgery for endocarditis. He reiterated his October 6, 2009 conclusion that the permanent disability was 100% industrial and stated that any worsening constituted a repetitive trauma injury. (*Id.* at p. 13.)

In his reevaluation of applicant on September 11, 2019, she expressed subjective complaints characterized by worsening right hand weakness, limited mobility, and an overall loss of use of her right hand and fingers. (Court Ex. Z9, pp. 1, 3.) She described achiness, intermittent numbness, and an inability to open her right hand independently, noting she relies on her opposite hand to pry her fingers open. Additional subjective complaints included back pain, bilateral knee pain, neck pain, bilateral trapezius and shoulder pain, and chest pain. (*Id.* at p. 3.)

AME Dr. Wertheimer diagnosed applicant with a peripheral nerve lesion of the right upper extremity caused by a surgical complication. (*Ibid.*) AME Dr. Wertheimer traced the impairment back to January 2011 when a staphylococcal infection involving Staph aureus in the left knee developed into severe septicemia, meningitis, and endocarditis. Treatment for these complications required open-heart surgery to replace a valve, after which applicant awoke with right hand muscle paralysis. AME Dr. Wertheimer identified an ulnar nerve compression injury sustained during the open-heart surgery. (*Id.* at p. 12.) He apportioned the entire disability to the industrial injury, finding that the impairment resulted solely from medical treatment of the original industrial left knee injury. (*Id.* at p. 14.)

In calculating permanent disability, he quantified total cervical region ROM impairment at 9% WPI. (flexion at 45° (2% WPI), extension at 42° (2% WPI), left lateral bending at 28°, (2% WPI) right lateral bending at 33° (1% WPI), left rotation at 67° (1% WPI), and right rotation at 64°

(1% WPI)) (AMA Guides, Table 15-12, p. 418; 15-13, p. 420, 15-14, p. 421.) (*Id.* at pp. 7-8.) Evaluation of the upper extremities yielded 6% UE impairment for the left shoulder and 6% UE impairment for the right shoulder (180° of bilateral flexion, 30° of bilateral extension, 90° of bilateral external rotation, 30° of bilateral internal rotation, 180° of bilateral abduction, and 20° of bilateral adduction) (AMA Guides, Figure 16-40, p. 476; Figure 16-43, p. 477; Figure 16-46, p. 479.) (*Id.* at pp. 8-10.) For the specific right upper extremity ulnar nerve injury, he evaluated sensory and motor loss. (AMA Guides, Table 16-10, p. 482; Table 16-11, p. 484.) By combining the motor and sensory deficits, he calculated 50% UE impairment. (AMA Guides, Table 16-15, p. 492.) He then converted this value into 30% WPI for the right upper extremity. (AMA Guides, Table 16-3, p. 439.) Finally, AME Dr. Wertheimer reduced this 30% WPI by 25% WPI to account for residual functionality, noting applicant retained her ability to drive and manipulate a steering wheel. The calculation produced a final rating of 23.5% WPI for the right ulnar nerve injury, and AME Dr. Wertheimer recommended adding the rating to her overall impairment from the knee trauma.[3] (*Id.* at p. 14.)

On January 26, 2023, he provided deposition testimony addressing the complexities of apportionment. He confirmed he had previously attempted to apportion the disability by assigning one-third to prior specific injuries and two-thirds to cumulative trauma in his August 22, 2022 report. (Court Ex. Z10, p. 6:4-7; Court Ex. Z11, pp. 2-3.) However, he testified that the specific dates of injury and the cumulative trauma periods overlap and intertwine rendering apportionment inherently speculative. (Court Ex. Z10, p. 10:2-9.) He stated that apportioning the disability among the three dates of injury in accordance with *Benson* to a reasonable degree of medical probability would merely be a gross estimate. (*Id.* at p. 10:20-25 to 11:1-16.) He concluded that the original injuries leading to the infection are responsible for the overall condition and that determining an exact apportionment percentage remains difficult and highly speculative. (*Id.* at pp. 11:19-25 to 12:1-10, 13:9-18.)

On September 22, 2014, AME Dr. Hyman evaluated applicant in the field of internal medicine. She subjectively complained of experiencing chest pain, palpitations, and ankle swelling

[3] We note several fundamental methodological and mathematical defects in this impairment calculation that preclude its standing as substantial medical evidence. The AMA Guides require an evaluator to establish the clinical severity grade of sensory and motor deficits using the appropriate upper extremity grading matrices before multiplying by the maximum peripheral nerve impairment values. (AMA Guides, Section 16.5b, pp. 481-482; Table 16-10a, p. 482; Table 16-11a, p. 484.) By abandoning this objective grading protocol in favor of an absolute maximum impairment coupled with a subjective, anecdotal discount, AME Dr. Wertheimer deviated from standard rating methodology without articulating a valid analysis pursuant to *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd*. (*Almaraz/Guzman III*) (2010) 187 Cal.App.4th 808, 822 [75 Cal.Comp.Cases 837] grounded within the four corners of the AMA Guides. Furthermore, a 25% reduction of 30% WPI mathematically yields 22.5%, rather than the 23.5% concluded in the report.

every other day, describing the chest pain as a central sharp sensation lasting from 2 to 30 seconds. (Court Ex. Y3, p. 3.) She additionally reported experiencing weight change, muscle pain, joint pain, joint swelling, back pain, constipation, poor memory, anxiety, and poor sleep. (*Id*. at p. 4.)

During the objective physical examination, AME Dr. Hyman observed that applicant was obese with a body mass index of 31 and presented with a well-healed midline scar alongside a longitudinal left knee scar. Auscultation of her cardiovascular system revealed a mechanical S1 heart sound heard best at the second right intercostal space. (*Id.* at p. 5.) Diagnostic chest x-rays demonstrated a status post sternotomy with a mechanical valve ring at the tricuspid position and a well-healed subcutaneous device. (*Id.* at p. 6.) An electrocardiogram showed a sinus rhythm with right bundle branch block formation, while an echocardiogram by Ram Dandillaya, M.D., dated September 22, 2014 revealed a bioprosthetic tricuspid valve, a pacing catheter in the right-sided chambers, mild tricuspid regurgitation, and an estimated ejection fraction of 60%. (*Id.* at pp. 7, 18.) AME Dr. Hyman noted that pulmonary function testing demonstrated no significant residual limitation, though he assessed minor residual impairment due to altered lung circulation. (*Id.* at p. 8.)

He opined that applicant sustained a documented history of industrially related orthopedic injuries to her left knee requiring repeated surgical interventions. He established that these repeated surgical interventions led to a Staph aureus septicemia infection when the bacteria, typically located on the skin, was introduced into her bloodstream. The bacteria caused a change to the interior of her heart and damaged the tricuspid valve. Consequently, AME Dr. Hyman concluded that all ongoing documented cardiopulmonary difficulties, including the emergency interventions at Lakewood Hospital and USC Hospital, represent industrially related consequences of her surgical orthopedic intervention. (*Ibid.*)

He assigned 9% WPI for the status post tricuspid valve replacement. (AMA Guides, Table 3-5, Class 1, p. 30.) He assigned 9% WPI for the status-post pacemaker placement with residual right bundle branch block formation. (AMA Guides, Table 3-11, Class 1, p. 56.) He assigned 5% WPI for pulmonary embolization. (AMA Guides, Table 4-3, Class 1, p. 70.) AME Dr. Hyman noted that the impairment ratings for the pacemaker and valve replacement consider each other to arrive at a fair impairment rating, and he rated the pulmonary embolus by analogy to aortic disease because it best approximated her altered circulatory condition. He determined applicant's cardiopulmonary complications directly resulted from her orthopedic conditions, formally concluding there was no basis for apportionment to non-industrial factors. (*Id.* at p. 9.)

In AME Dr. Hyman's reevaluation dated January 18, 2016, he recorded applicant's subjective complaints as including depression, a decrease in appetite, and weight loss down to 160 pounds. She reported developing neck headaches with a dull sensation in 2014, accompanied by dizzy spells, watery or itchy eyes, and ringing of the ears. She describes experiencing chest pain, palpitations, and ankle swelling, specifically noting sharp left-sided chest pains lasting two seconds that occur twice a week. She also complained of ongoing joint pain, joint swelling, back pain, and heartburn occurring twice daily for many years, which she treats with papaya seeds. (Court Ex. Y1, p. 2.) Furthermore, she reports poor memory, anxiety, and panic attacks resulting in poor sleep. (*Id.* at p. 3.)

AME Dr. Hyman measured applicant's height at 5 feet 3.5 inches, weight at 162 pounds, and blood pressure at 130/80. (*Ibid*.) She had a well-healed sternotomy scar and a left upper chest wall scar with a subcutaneous pacemaker. (*Id.* at p. 4.) An electrocardiogram showed a sinus rhythm with a right bundle branch block. (*Id.* at p. 5.) A capsule endoscopy performed the same day revealed mild esophagitis and a questionable hiatal hernia. (*Id.* at pp. 5, 17.) An exercise treadmill test concluded after 4.5 minutes due to fatigue, reaching 85% of her maximum predicted heart rate, indicating a low probability of coronary artery disease. (*Id.* at pp. 5-6.) A urinalysis indicated a urinary tract infection. (*Id.* at p. 4.)

He concluded that applicant's endocarditis, tricuspid valve replacement, pacemaker placement, right bundle branch block formation, and septic emboli to the lungs are industrially related. (*Id.* at p. 6.) He determined that her chest pain complaints result from the sternotomy procedure and do not present a ratable impairment. AME Dr. Hyman stated that applicant's stress tension-type headaches with dizziness stem from her psychological difficulties ultimately deemed industrial by AME Dr. Greils. Regarding the gastroesophageal reflux disease, AME Dr. Hyman concludes it was partially industrial due to the pain of applicant's injuries, the stress of her injuries, and her psychological condition. (*Id.* at p. 7.)

He assessed 2% WPI for stress tension-type headaches (AMA Guides, Table 18-1, p. 571) and 9% WPI for gastroesophageal reflux disease. (AMA Guides, Table 6-3, Class 1, p. 121.) (*Id.* at p. 8.)

In his apportionment analysis, Dr. Hyman concluded in his March 16, 2023 supplemental report that his apportionment for the internal medicine conditions parallels the exact percentages established by AME Dr. Wertheimer and AME Dr. Greils across the respective claim periods. (Court Ex. Y5, p. 2.)

In his report dated September 7, 2016, AME Dr. Greils, after evaluating applicant in the field of psychiatry, attributed the onset of her physical and emotional conditions predominantly to her occupational duties. (Court Ex. X2, p. 127.) She reported that her job required repetitive physical motions and the physical restraint of minors, which caused her to develop severe bilateral knee pain beginning in approximately 2005. (*Id.* at p. 7.) She stated that diagnostic imaging revealed a torn anterior cruciate ligament and meniscus in her left knee, leading to multiple unsuccessful surgical repairs. (*Id.* at pp. 8-9.) She reported that she continued working despite chronic pain and began experiencing severe sleep disturbances, anxiety, and depression by 2006, prompting her to file an initial workers' compensation claim. (Court Ex. X2, p. 8.)

Beginning in early 2011, applicant's health suffered a significant deterioration when she lost consciousness and required emergency hospitalization for a severe staph infection, meningitis, and jaundice. (*Id.* at pp. 10-11.) Physicians diagnosed her with an exploded tricuspid valve, necessitating immediate open-heart surgery for a valve replacement, along with the surgical cleaning of her left knee to remove the staph infection. (*Id.* at pp. 11, 78.) Following the heart surgery, she required the implantation of a pacemaker and experienced right arm paralysis attributed to surgical nerve damage. (*Id.* at pp. 6, 11-12, 18, 78.) She stated that her extended stay in the intensive care unit traumatized her, resulting in panic attacks, flashbacks, and a brief, unsuccessful suicide attempt via pill overdose. (*Id.* at pp. 12, 14, 72, 80, 110.) She underwent a left knee replacement in 2011 and eventually returned to work on limited duty in April 2012, though she reports enduring constant severe physical pain, ongoing panic attacks, and crying spells in the workplace. (*Id.* at pp. 13-14, 80-81.) She noted that her supervisors frequently ignored her medical work restrictions, exacerbating her physical pain and psychological distress. (*Id.* at p. 17, 83, 88, 95.)

She described her current life situation as highly restricted, noting that she suffers from severe insomnia, averaging only three hours of sleep per night due to physical pain and daily nightmares regarding twisted memories. (*Id.* at pp. 20, 103.) She reports isolating herself from social interactions, completely losing her sex drive, and experiencing severe anxiety in crowded environments, such as a recent trip to an amusement park that triggered a severe panic attack. (*Id.* at pp. 21-22, 97, 106.) She reported ongoing marital stress after her husband lost his job in December 2015 and engaged in infidelity in early 2016. (*Id.* at pp. 16, 83, 87, 94.) She states that she sought medical retirement in 2015 based on evaluations from other AMEs who concluded she could no longer safely perform her job duties. (*Id.* at p. 17, 84, 95.)

During her psychological testing, she was cooperative but a poor historian. (*Id.* at p. 35.) During the testing, she would rub her back and shift positions in her chair. (*Id.* at p. 34.) AME Dr. Greils assessed her mood as depressed and anxious, rating her depression at a 3 out of 5 scale, noting intermittent sobbing alongside an abnormal level of emotional reactivity. (*Id.* at p. 35.) Her objective psychometric testing results indicated cognitive functioning within the low average to high average range, with applicant scoring in the 75th percentile on vocabulary and the 16th percentile on digit span and arithmetic subtests. (*Id.* at pp. 28-29.)

AME Dr. Greils found the Taylor-Johnson Temperament Analysis of questionable validity because of a negative test-taking bias and deemed the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) results invalid because of the large number of unusual responses. (*Id.* at p. 32.) The Epworth Sleepiness Scale yielded a score of 12, indicating excessive daytime sleepiness. (*Id.* at p. 34.)

AME Dr. Greils diagnosed under Axis One as Depressive Disorder Not Otherwise Specified with anxious features, Posttraumatic Stress Disorder of Delayed Onset, Sleep Disorder due to Pain and nightmares, and Female Hypoactive Sexual Desire Disorder Due to Pain with a Global Assessment of Functioning (GAF) score of 53 (23% WPI) (*Id.* at p. 71.) This correlates to moderate symptoms or moderate difficulty in social or occupational functioning. He also provided a historical timeline of her functioning, estimating a pre-morbid GAF score of 90 and a subsequent decline to 30 following a suicide attempt. (*Id.* at p. 72.) He identified contributing psychosocial stressors on Axis Four, which included stress secondary to orthopedic injury, internal medicine injury, her husband's unemployment, financial debt, and the death of a co-worker. (*Id.* at p. 71.)

In his reexamination report dated June 1, 2017, he recorded applicant's subjective physical complaints, which included constant pain in the low back and bilateral knees, chest pain, and partial paralysis in the right hand. She estimated her physical condition deteriorated by 20% since her original injury. AME Dr. Greils noted she experiences anxiety, sadness, poor sleep, anger, and specific triggers. (Court Ex. X1, p. 6.) She described suffering from anxiety attacks, breathing difficulties, sweating, and daily chest discomfort that typically occurs at night. She confirmed her emotional condition worsened but does not quantify the deterioration with a specific percentage. (*Id.* at p. 7.)

She medically retired from her job on December 7, 2016. She did not receive psychiatric treatment until March 2017, when she attended a single session with Perry Maloff, M.D., which she found unhelpful and detrimental to her mental state. She reports the workers compensation system

denied physical treatment, causing her to feel stagnant and tired of the process. (*Ibid.*) She currently manages her symptoms independently through prayer and yoga, and she expresses a strong desire to settle and close her case. (*Id.* at pp. 8, 13, 39-40, 42, 45.) She takes Xanax up to three times daily, Motrin, Aspirin, a water pill, and Norco. (*Id.* at p. 9.)

She requires her husband's physical assistance with personal hygiene. She prepares limited meals and receives household assistance from her mother-in-law, avoiding yard work entirely due to pain. (*Id.* at p. 10.) She reported poor sleep quality, averaging four hours per night, and identified anxiety as the primary disturbance, followed by physical pain. (*Id.* at pp. 11-12, 50.) She experienced nightmares about twice a week, occasional flashbacks, and avoids hospitals, crowds, and violent television. (*Id.* at p. 12-13, 45, 50.)

The Bender Visual Motor Gestalt Test and Memory for Designs Test revealed no evidence of organic errors. (*Id.* at p. 20.) The Babcock Story Recall Test demonstrated low-average initial recall and above-average secondary recall. (*Id.* at pp. 20-21.) The Wechsler Adult Intelligence Scale, Fourth Edition subtests indicated average short-term memory and general knowledge, with low-average arithmetic performance. The MMPI-2 noted a significantly elevated F scale score of 72, which suggests applicant may slightly overstate her symptomatology. (*Id.* at p. 21.) Clinical scale elevations occurred in hypochondriasis, depression, hysteria, psychopathic deviate, paranoia, psychasthenia, schizophrenia, and social introversion. (*Id.* at p. 22.) He categorizes the MMPI-2 findings as a 213/231 code profile, stating this pattern is consistent with individuals experiencing emotional suffering who need to call attention to their pain, often presenting with somatic complaints and potential secondary gain. (*Id.* at p. 25.)

Applicant reported subjective feelings of depression, equating to a three on a zero to five scale, alongside sadness, anger, and anxiety. (*Id.* at pp. 27, 41.) She experiences daily anxiety attacks and difficulty breathing, typically at night, and reports sweating and chest discomfort. (*Id.* at p. 41.) She struggles with sleep, obtaining an average of four hours per night, and awakens two to three times nightly due to pain. (*Id.* at pp. 11, 50.) She details nightmares occurring twice a week and occasional flashbacks. (*Id.* at pp. 12, 45, 50.) She takes Xanax at least once daily to manage anxiety and utilizes prayer and yoga for coping. (*Id.* at pp. 8, 40, 45.)

She scored 10 on the Epworth Sleepiness Scale indicating excessive daytime sleepiness. (*Id.* at p. 26.) She was cooperative and attentive but noted she was a poor historian with an affect ranging from blunted to hypervigilant to tearful. (*Id.* at p. 27.) She demonstrated pain-related behaviors, including frequent shifting, rubbing her back, and standing. (*Id.* at p. 26.) AME Dr. Greils

found applicant's memory slightly impaired, noting difficulty recalling specific dates and details, and observed that pain and anxiety affected her concentration over prolonged periods. She showed impairment in performing serial sevens but completed serial fives without errors. (*Id.* at p. 28.) Psychometric testing provided a pattern of elevations on scales one, two, three, and seven, supporting diagnoses related to somatic complaints, anxiety, and depression. (*Id.* at pp. 22, 42, 46.)

AME Dr. Greils diagnosed applicant with Depressive Disorder Not Otherwise Specified with anxious features, Posttraumatic Stress Disorder with delayed onset, Sleep Disorder due to pain, and Female Hypoactive Sexual Desire Disorder due to pain with a GAF score of 52 (27% WPI). (AMA Guides, Table 14-1, p. 363; 14-2, p. 367.) (*Id.* at pp. 36-37, 53, 55, 59, 68.) In addition, work function impairments comprise moderate across work pace, complex tasks, interpersonal relations, influencing others, independent decision-making, and carrying out responsibility, with slight impairment in following instructions and very slight impairment in simple tasks. (*Id.* at pp. 71–72.)

AME Dr. Greils determined the psychiatric injury predominantly resulted from the pain, limitations, and sequelae caused by her orthopedic condition. Because AME Dr. Wertheimer found the orthopedic condition to be industrial in causation, AME Dr. Greils concluded the psychiatric injury is also industrial in causation and apportioned it entirely to the stress secondary to the orthopedic pain and limitations and her accompanying complications. (*Id.* at pp. 33, 61.)

In his vocational report dated September 17, 2018, Mr. Vega, after evaluating applicant, took a history that she last worked in December 2016 and attempted a brief return to work as a general office clerk in March and April 2017, which she could not sustain due to panic attacks and an inability to get out of bed. (App. Ex. 2, pp. 3, 5.) Her employment history includes work as a Probation-and-Parole Officer and Teacher Aide II, both of which required light strength. (*Id.* at p. 4.) Mr. Vega notes that applicant cannot return to her previous physical occupations and she possesses no transferable skills for lighter occupations. (*Id.* at p. 12.)

Vocational testing administered on June 13, 2018, demonstrated average non-verbal intellectual functioning and academic achievement but revealed significant physical and cognitive limitations. (*Id.* at pp. 5-7.) Applicant scored in the very low to below-average ranges on the Purdue Pegboard Test, demonstrating poor finger dexterity while actively holding her right hand with her left hand due to nerve damage. (*Id.* at p. 6.) She discontinued the Minnesota Rate of Manipulation Tests due to right hand pain and worked at a slow pace. Furthermore, she scored in the very low range on the Minnesota Clerical Test and the Bennett Mechanical Comprehension Test. (*Id.* at p. 8.) She could not complete the Wide Range Achievement math computation subtest, the

Gates-MacGinitie reading comprehension section, or the Bennett Mechanical Comprehension Test within the allotted times, which Mr. Vega attributes to problems with concentration, persistence, and pace. (*Id.* at pp. 7-9.)

Mr. Vega opined that, considering the AMEs opinions and his evaluation, applicant is permanently and totally disabled, non-feasible for vocational rehabilitation, and unable to perform even basic job duties. (*Id.* at p. 2.) Her post-injury access to the open labor market and work life expectancy have fallen to zero. (*Id.* at pp. 13-14.) Mr. Vega emphasizes that while there is medical apportionment to earlier continuous trauma periods, applicant returned to work after 2009, meaning her total inability to compete in the open labor market stems entirely from her most recent industrial orthopedic impairments and the ensuing psychiatric and internal medicine complications. (*Id.* at p. 18.)

In his supplemental report dated August 21, 2020, Mr. Vega conducted new vocational testing on July 1, 2020, at the request of applicant's attorney to eliminate any potential distraction caused by the presence of applicant's son during the initial evaluation. (App. Ex. 6, pp. 1, 7.) During the evaluation, Mr. Vega observed that applicant provided her best effort but worked at a slow pace, alternated between sitting and standing, and frequently stretched or massaged her right hand. She appeared visibly tired and in pain by the end of the session, remarking that her entire body hurt. (*Id.* at p. 5.)

With respect to her vocational tests, on the Purdue Pegboard Test, she scored in the very low range for the right hand and both hands subtests, experiencing difficulty opening her right hand due to reported nerve damage and utilizing her left hand to assist the right. She discontinued the assembly subtest due to hand problems, indicating she would not be competitive for positions requiring strong finger dexterity. (*Id.* at p. 2.) She also attempted the Bennett Hand-Tool Dexterity Test and the Minnesota Rate of Manipulation Tests but discontinued both early due to severe right hand pain, demonstrating limited potential for occupations requiring manual dexterity. (*Id.* at pp. 3-4). Additionally, her right arm visibly shook during the Minnesota Clerical Test, where she scored in the very low range, indicating limited aptitude for clerical work. (*Id.* at p. 4.)

With respect to her cognitive and academic testing, the Beta Four assessment placed her non-verbal intellectual functioning in the low average range, a decrease from her prior score that Mr. Vega attributes to pain and a test version change. (*Id.* at pp. 2-3, 6.) While the Wide Range Achievement Tests showed average functioning in word reading, sentence comprehension, and math computation, applicant scored below average in spelling, experiencing writing difficulties and

massaging her right wrist during the subtest. (*Id.* at p. 3.) She failed to complete the Gates-MacGinitie Reading comprehension section and the Bennett Mechanical Comprehension Test within the allotted times, which Mr. Vega attributes to ongoing problems with concentration, persistence, and pace stemming from deterioration of her medical condition. (*Id.* at pp. 4-6.)

Mr. Vega concluded that applicant's scores remain largely consistent with the previous findings, confirming persistent deficits in manual dexterity, finger dexterity, and clerical aptitude. (*Id.* at p. 6.) He noted that her performance deteriorated on several tests in 2020 primarily due to pain. Relying on these consistent testing results and her significant physical impairments, Mr. Vega affirmed his previously expressed opinion that applicant cannot benefit from vocational rehabilitation services and possesses no access to employment in the open labor market. (*Id.* at p. 7.)

III.

As stated above, in our prior Opinion and Order Granting Petition for Reconsideration and Decision After Reconsideration, dated January 24, 2024, we rejected defendant's contention that the WCJ had improperly circumvented the statutory apportionment requirements imposed by section 4663 and *Benson*. We explained that, because defendant bore the burden of proving apportionment, its failure to carry that burden warranted an unapportioned award of permanent disability, and we further held that we had no duty to require development the record to assist defendant in satisfying that evidentiary burden. Nevertheless, in our subsequent Opinion and Order Granting Petition for Reconsideration, dated August 9, 2024, we found good cause to grant reconsideration and defer a final decision. This deferral allowed for further review of the AME reporting and the potential applicability of apportionment pursuant to section 4664(c), taking into consideration the interrelationship between the previously resolved stipulations for the October 1, 2008 to October 1, 2009 injury and the currently litigated reopened October 1, 2009 to January 1, 2011 injury. We now issue our decision in accordance with that review.

DISCUSSION

IV.

The Appeals Board has the *discretionary* authority to develop the record when the record does not contain substantial evidence or when appropriate to provide due process or fully adjudicate the issues. (Lab. Code, §§ 5701, 5906; *Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389, 394 [62 Cal.Comp.Cases 924] ["principle of allowing full development of the evidentiary record

to enable a complete adjudication of the issues is consistent with due process in connection with workers' compensation claims."]; see *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117, 1121 [63 Cal.Comp.Cases 261]; *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2001) 67 Cal.Comp.Cases 138, 142 (Appeals Board en banc).

Section 4664(c) states:

> (c) (1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:
>
> (A) Hearing.
>
> (B) Vision.
>
> (C) Mental and behavioral disorders.
>
> (D) The spine.
>
> (E) The upper extremities, including the shoulders.
>
> (F) The lower extremities, including the hip joints.
>
> (G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

In prior panel decisions, the Appeals Board has often taken a commonsense approach to assignment of disability to a body system. (See e.g., *Jordan v. California Dep't of Corrections*, [2018 Cal. Wrk. Comp. P.D. LEXIS 243, *5][4] [Wherein the panel, using the chapters of the AMA Guides, assigned cognitive impairment as a "mental and behavioral" disability under section 4664(c)(1)(C), and not disability to the "head" under section 4664(c)(1)(G).].) However, when the issue of assignment of a disability to a body system exists and is in dispute, such issue is of a medical nature, and the determination requires substantial medical evidence.

To constitute substantial evidence ". . . a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on

[4] Unlike en banc decisions, panel decisions are not binding precedent on other Appeals Board panels and WCJs. (See *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) However, panel decisions are citable authority and we consider these decisions to the extent that we find their reasoning persuasive, particularly on issues of contemporaneous administrative construction of statutory language. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 242, fn. 7 (Appeals Board en banc); *Griffith v. Workers' Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1264, fn. 2 [54 Cal.Comp.Cases 145].) Here, we refer to these panel decisions because they considered a similar issue.

an adequate examination and history, and it must set forth reasoning in support of its conclusions." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).)

"[T]he medical cause of an ailment is usually a scientific question, requiring a judgment based upon scientific knowledge and inaccessible to the unguided rudimentary capacities of lay arbiters." (*Peter Kiewit Sons v. I.A.C.* (*McLaughlin*) (1965) 234 Cal.App.2d 831, 839 [30 Cal.Comp.Cases 188].) "In a field which forces the experts into hypothesis, unaided lay judgment amounts to nothing more than speculation." (*Id.* at p. 840.)

The requirement for expert medical evidence exists throughout workers compensation proceedings, including determination of temporary disability, permanent disability, apportionment, and causation of injury to name a few. (See also *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 621 [wherein the Appeals Board required that apportionment under section 4663 be established by substantial medical evidence].)[5]

In many cases, it may be apparent, even to the layperson, what disability affects which body system. In such cases, the parties may stipulate to body systems under section 4664(c). However, as stated, where the parties dispute the body system, such a dispute requires medical evidence, especially where there are issues outside the knowledge of a layperson required to decide the issue.

The requirements for proving application of section 4664(c) are essentially no different than apportionment under 4664(b):

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

(*Kopping v. Workers' Comp. Appeals Bd*. (2006) 142 Cal.App.4th 1099, 1115 [70 Cal.Comp.Cases 1229].)

In both 4664(b) and 4664(c), defendant is proving overlap. The difference between the two sections is that 4664(b) focuses on overlapping disability, whereas **4664(c) focuses on overlapping**

[5] In the past, courts have described application of section 4664(c) as "apportionment." (*Gordon v. County of L.A.* [2010 Cal. Wrk. Comp. P.D. LEXIS 581, *11-12].) The Appeals Board has also found that 4664(c) is not "apportionment." (*McGowan v. City of L.A*. [2015 Cal. Wrk. Comp. P.D. LEXIS 24 *7-8].) The issue is one of semantics that does not affect the analysis. Accordingly, we will use the term "application of section 4664(c)" throughout this opinion as referencing the process of calculating the application of section 4664(c).

body systems impacted by disability. This is an important distinction. Disability resulting from an industrial injury often differs from injury to a particular body part. However, substantial medical evidence must support those determinations.

Where defendant seeks to apply section 4664(c), and there is a dispute, defendant must do the following:

1) Establish a prior award(s) of disability.
2) Establish through expert medical evidence which body systems the prior disability affected.
3) Establish a current award of disability.
4) Establish through expert medical evidence which body systems the current disability impacts.

If applicant's disability spans multiple body systems, applicant may assign the disability to the body system that produces the highest rating.

The purpose of 4664(c) is to preclude accumulation of disability beyond 100% "with respect to any *one* region of the body." The overarching goal of rating permanent impairment is to achieve accuracy. (*Almaraz/Guzman III, supra,* 187 Cal.App.4th at p. 822) The Appeals Board has consistently held that when multiple methods can rate an employee's disability, they receive the higher rating. (*Ogilvie, supra,* 197 Cal.App.4th at p. 1277 [permitting rebuttal of the rating schedule with alternative higher rating based upon diminished future earnings]; see also *Grossmont Union High School District v. Workers' Comp. Appeals Bd*. (*Burns*) (1997) 62 Cal.Comp.Cases 687, 688 (writ denied) [establishing dual occupational rule, which allows for higher of two ratings when applicant's occupation spans two categories]; *Hartford Accident & Indemnity Company v. Workers' Comp. Appeals Bd*. (*Suttner*) (1990) 55 Cal.Comp.Cases 127, 128 (writ denied); see also *Dalen v. Workmen's Comp. Appeals Bd*. (1972) 26 Cal.App.3d 497, 506 [37 Cal.Comp.Cases 393]; *Weyerhaeuser Co. v. Workers' Comp. Appeals Bd*. (*Acosta*) (2003) 68 Cal.Comp.Cases 99, 100 (writ denied).) We see no reason to deviate from prior logic.

When a disability affects multiple body systems, a physician may assign it to either system and should assign it to the system that produces the higher rating. (See e.g., *Serrano v. GMC*, [2013 Cal. Wrk. Comp. P.D. LEXIS 28, *12-13] [Finding that 4664(c)(1) does not apply where fibromyalgia affected multiple body systems and not just applicant's upper extremities.].)

Here, the precise application of the statutory framework regarding the accumulation of permanent disability requires a granular medical categorization of impairments that is currently

absent from the evidentiary record. While the AMEs have extensively documented the profound physical and psychological deterioration of applicant, their reporting does not allocate these individual impairments into the strict anatomical regions mandated by section 4664(c)(1). The record shows that prior compensated awards involved the left lower extremity, right upper extremity, and cardiovascular system. The current claim involves overlapping pathology within these exact same physiological systems alongside newly claimed psychiatric and gastrointestinal impairments. However, the AMEs have not provided the necessary analytical bridge to determine which specific portion of the current overall occupational disablement belongs to each respective anatomical region. Without this explicit medical delineation, we cannot determine whether the disability for any single body region exceeds its lifetime maximum allowable rating. The AMEs must strictly assign both the prior functional deficits and the current functional deficits to their correct statutory categories to evaluate potential overlap.

Because the assignment of body systems overlap remains a strictly medical issue requiring scientific expertise beyond the purview of lay decision-makers, the evidentiary record requires further development. Return of this matter to the trial level is therefore essential for the parties to solicit supplemental expert opinions that explicitly parse the extensive medical and vocational impairments into their proper regional classifications. In light of our decision that such further expert medical opinion is necessary, we make no finding with respect to defendant's contention regarding apportionment per *Nunes I*.

V.

Section 3208.1 provides that an injury may be either cumulative or specific. No cumulative injury can occur without disability. (*Van Voorhis v. Workmen's Comp. Appeals Bd*. (1974) 37 Cal.App.3d 81, 86–87 [39 Cal.Comp.Cases 137]; *Aetna Cas. & Surety Co. v. Workmen's Comp. Appeals Bd*. (*Coltharp*) (1973) 35 Cal.App.3d 329, 342–343 [38 Cal.Comp.Cases 720].) A cumulative injury is one that occurs as "repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment." (Lab. Code, § 3208.1(b).) Section 3208.1(b) further provides that "[t]he date of a cumulative injury shall be the date determined under Section 5412." (*Ibid*.)

Section 3208.2 states that:

> When disability, need for medical treatment, or death results from the combined effects of two or more injuries, either specific, cumulative, or both, all questions of fact and law shall be separately determined with respect to

> each such injury, including, but not limited to, the apportionment between such injuries of liability for disability benefits, the cost of medical treatment, and any death benefit.

(Lab. Code, § 3208.2.)

The issue of how many cumulative injuries an employee sustained is a question of fact for the Appeals Board. (See *Coltharp, supra*, 35 Cal.App.3d at p. 341 [Applicant sustained two separate cumulative injuries, one before and one after the initial period of disability and need for treatment; to conclude otherwise would violate the anti-merger provisions of sections 3208.2 and 5303]; *Western Growers Ins. Co. v. Workers' Comp. Appeals Bd*. (*Austin*) (1993) 16 Cal.App.4th 227, 234–235 [58 Cal.Comp.Cases 323] [Applicant had one continuous compensable injury because, unlike *Coltharp*, his two periods of temporary disability were linked by the continued need for medical treatment and the two periods were not "distinct."].)

Harmonizing the holdings of *Austin* and *Coltharp* produce the following principles:

(1) If, after returning to work from a period of industrially-caused disability and a need for medical treatment, the employee's repetitive work activities again result in injurious trauma, i.e., if the employee's occupational activities after returning to work from a period of temporary disability cause or contribute to a new period of temporary disability, to a new or an increased level of permanent disability, or to a new or increased need for medical treatment, then there are two separate and distinct cumulative injuries that cannot be merged into a single injury (Lab. Code, §§ 3208.1, 3208.2, 5303; *Coltharp, supra*, 35 Cal.App.3d at p. 342); and

(2) If the employee's occupational activities after returning to work from a period of industrially-caused disability are not injurious, i.e., if any new period of temporary disability, new or increased level of permanent disability, or new or increased need for medical treatment result solely from an exacerbation of the original injury, then there is only a single cumulative injury and no impermissible merger occurs. (Lab. Code, §§ 3208.1, 3208.2, 5303; *Austin, supra*, 16 Cal.App.4th at p. 235.)

Here, a fundamental factual ambiguity remains unresolved concerning the etiology of the catastrophic systemic failures, specifically, whether they resulted from a new period of cumulative trauma or constituted compensable iatrogenic consequences of prior medical interventions attributable to prior injurious exposure. The medical evidence details a tragic sequence of events wherein routine therapeutic injections and surgical procedures introduced a devastating bacterial

infection into the bloodstream. The AMEs describe the subsequent emergency cardiac valve replacement and the neurological injuries sustained under anesthesia as direct consequences of treatment for the primary orthopedic condition. This medical cascade strongly suggests that the ensuing cardiovascular, neurological, and psychiatric disabilities represent adverse treatment outcomes stemming from the original injury, rather than a distinctly new period of repetitive workplace trauma. Although the AMEs reference overlapping dates of injury, they simultaneously attribute the totality of the severe internal and psychological decline to the infectious complications of the orthopedic surgeries. Furthermore, Mr. Vega's vocational reports conclude that applicant has lost all access to the open labor market, yet the combined effects of the surgical complications, rather than new workplace duties, caused this profound occupational exclusion. We must evaluate this evidentiary overlap to determine if applicant suffered a single, protracted period of injury linked by an ongoing need for medical care, or multiple separate injuries. Unfortunately, the current medical record falls short of this legal standard.

For example, during his January 26, 2023 deposition, AME Dr. Wertheimer clarified his apportionment analysis and ultimately determined that the various dates of injury overlapped and shared the same underlying causes. He acknowledged that his prior attempt to assign one-third of the disability to specific injuries and two-thirds to cumulative trauma was inherently speculative. He testified that the specific injury dates and the cumulative trauma periods overlap so heavily that attempting to separate them is simply not possible. He explained that the original injuries triggered an infectious medical cascade that was entirely responsible for the overall condition. As a result, any effort to divide the resulting disability among the three distinct dates of injury to a reasonable degree of medical probability would be nothing more than a gross estimate.

Similarly, AME Dr. Hyman echoed this diagnostic overlap in his assessment of the internal and neurological sequelae. While he meticulously detailed the timeline of the bacterial infection and the subsequent need for the emergency cardiac valve replacement, his reports do not adequately isolate the resulting functional deficits. Instead, he treated the internal decline as a direct continuum of the initial surgical complications. Like AME Dr. Wertheimer, AME Dr. Hyman concluded that assigning discrete percentages of internal disability to separate periods of trauma would be medically unsound given the cascading nature of the infection. However, acknowledging the catastrophic trajectory of applicant's decline is not a substitute for the rigorous analysis required to determine whether these internal injuries represent a legally distinct new cumulative trauma or a compensable consequence of the previous resolved cumulative trauma.

The psychiatric analysis provided by AME Dr. Greils presents a mirroring evidentiary deficiency. Evaluating the profound psychological impact of the medical cascade, he attributed the psychiatric disability to the aggregate trauma of the physical decline and the total loss of labor market access. Although his reports comprehensively outline the severity of the psychological condition, they fail to assign the psychiatric deficits strictly to their correct statutory categories. By tethering the psychiatric impairment to the inextricably intertwined physical conditions, he bypassed the necessary step of identifying the specific pathogenesis of the psychological injury. The medical record must clarify whether the psychiatric condition is a compensable consequence flowing directly from the surgical trauma or if it developed independently alongside a new period of cumulative trauma.

While the testimonies and reports of the AMEs established that providing an exact apportionment percentage based on current data is medically speculative, deeming the injuries inextricably intertwined does not cure the need to trace the specific pathological cause of the condition. To justify an unapportioned award or to evaluate overlap with accuracy, the medical evidence must bridge the gap between their findings of an intertwined medical cascade and the legal requirement to delineate functional deficits. Resolving this factual discrepancy is paramount because a finding that the latter impairments are merely compensable consequences of the initial medical treatment would fundamentally alter the requisite apportionment calculus. Consequently, we must return this matter to the trial level for a definitive factual determination on the number and nature of the injuries sustained, strictly guided by the AMEs outlining the origin of the systemic infections.

Accordingly, as our Decision After Reconsideration we rescind the WCJ's decision and substitute a new decision deferring issues related to permanent disability and attorney fees. We otherwise make no substantive changes to the decision.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the June 3, 2024 Second Amended Findings and Award is **RESCINDED** with the following **SUBSTITUTED** therefor:

FINDINGS OF FACT

1. Nerissa Watson, while employed during the period October 1, 2009 to January 1, 2011 as a Detention Services Officer, Occupational Group Number 490, at Los Angeles, California by the County of Los Angeles, permissibly self-insured, administered by Sedgwick Claims Management Services, Inc., sustained injury

arising out of and in the course of employment to her right wrist, right hand, left knee, heart and lungs, psyche, headaches, and gastrointestinal system.

2. At the time of the injury, the employee's earnings were $1142.54 per week.

3. Permanent disability is deferred.

4. Apportionment is deferred.

5. Applicant will require further medical treatment to cure or relieve from the effects of this injury.

6. Attorney fees are deferred.

AWARD

AWARD IS MADE in favor of Nerissa Watson against the County of Los Angeles, permissibly self-insured, administered by Sedgwick Claims Management Services, Inc., as follows:

1. Further medical treatment in accordance with Findings of Fact 5 above.

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG L. SNELLINGS, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

ANNE SCHMITZ, DEPUTY COMMISSIONER
CONCURRING NOT SIGNING

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

August 28, 2026

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

NERISSA WATSON
BURGIS & ASSOCIATES, P.C.
RK LAW WC, APC

DLP/md

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

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

LAWRENCE THOMPSON, *Applicant*

vs.

HOBBY LOBBY STORES, INC., insured by
ACE AMERICAN INSURANCE COMPANY, *Defendants*

Adjudication Number: ADJ18042476
Sacramento District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND OPINION AND DECISION AFTER RECONSIDERATION

Applicant seeks reconsideration of the Findings of Fact and Award (F&A) issued by the workers' compensation administrative law judge (WCJ) on May 14, 2026, which found in relevant part that applicant sustained injury arising out and in the course of employment to his low back and shoulders while employed as a stockman/retail laborer for defendant on April 14, 2023; that applicant's occupational group is 360; and that applicant's injury caused permanent disability of 35 percent.

Applicant contends that the WCJ incorrectly rejected an alternative assessment of impairment that was based on an "*Almaraz/Guzman*" rating (See *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd*. (referred to herein as *Almaraz/Guzman*) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837]). Applicant further contends that the applicable occupational group number in the permanent disability rating schedule (PDRS) is 470.

We have not received an Answer from defendant.

The WCJ has prepared a Report and Recommendation on Petion for Reconsideration (Report), recommending that we deny reconsideration.

We have considered the contents of the Petition, the Answer, the WCJ's Report, and the record herein. For the reasons set forth below, we will grant the Petition for Reconsideration, and

as our Decision after Reconsideration we will rescind the F&A and substitute a new F&A that defers the issues of permanent disability, attorney's fees and the occupational group number, and return the matter to the trial level for further development of the record.

FACTS

On April 28, 2026, the parties proceeded to trial. Issues submitted for decision included permanent disability, apportionment, and occupational group number, with applicant claiming that the occupational group number is 470, and the employer claiming the group number is 214. (Minutes of Hearing and Summary of Evidence, April 28, 2026 (MOH) p. 2, lines 21-25.)

The parties stipulated that applicant sustained an industrial injury to the low back and shoulders on April 14, 2023. (*Id*. at p. 2, lines 5-7.) The parties both relied upon the medical expert opinions of Qualified Medical Evaluator (QME) David Smolins, M.D. (Joint Exhibits 1- 6).

In his report dated September 26, 2025, the QME found that applicant had reached maximal medical improvement. Dr. Smolins assessed percentages of permanent impairment for the low back and shoulders using the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides, or Guides). His assessment of impairment of the lumbar spine is as follows:

> Utilizing the AMA Guides 2001, Fifth Edition, chapter 15, page 384, table 15-3, he falls into DRE Lumbar Category II with an 8% whole person impairment…
>
> …As per the Almaraz-Guzman decision, one may analogize to a separate corner of the Guides. Mr. Thompson is found to have an 8% whole person impairment for the lumbar spine as per the strict rating. However, the Guides in their strictest sense do not accurately take into account the limitations in activities of daily living. Said another way, one would not expect an 8% whole person impairment given the limitations in his ADLs as noted in today's reporting. He would more accurately be rated via chapter 6, page 136, table 6-9 in Class II. His injury correlates with a Class II, noting frequent discomfort which precludes heavy lifting, but not hampering some activities of daily living. This accurately describes Mr. Thompson and yields a 15% whole person impairment.

(Joint Exhibit 5, QME report of David Smolins, M.D., September 26, 2025, pp. 12-13.)

In his supplemental report of November 23, 2025, the QME corrected some typographical errors in his assessment of impairment of the shoulders and explained his recommendation that percentages of disability of the back and shoulders be added and not combined because their effects on activities of daily living overlap but also amplify each other. In the supplemental report, the QME does not discuss his *Almaraz/Guzman* rating of lumbar spine impairment. (Joint Exhibit 6, QME report of David Smolins, M.D., November 23, 2025, pp. 1-2.)

Defendant cross-examined the QME regarding his *Almaraz/Guzman* rating on February 24, 2026, as follows:

> Q Let's turn to page 12 of that September 26, 2025, report. That's where your discussion section starts and where there's impairment to the lumbar spine.
>
> Doctor, per the strict AMA Guides you placed the applicant in DRE Lumbar Category II with 8 percent whole person impairment; is that correct?
>
> A Correct.
>
> Q Okay. You went on to utilize Almaraz/Guzman analogizing to the hernia sections and placing the applicant in Class II with 15 percent whole person impairment, and stating that the impairment was awarded given the limitations in his activities of daily living as noted in today's reporting; was that correct, Doctor?
>
> A Yes.
>
> Q And then I note in the ADL section of your report, I believe it's on page 3, you just referred to the ADL worksheet. So what specific ADLs from that worksheet justify utilizing the rating by analogy in this case?
>
> A So the ADL worksheet does note limitations in lifting and carrying, and the hernia Table notes Class II of frequent discomfort precluding heavy lifting, but not hindering activities of daily living.
>
> So the ADL worksheet does list a number of ADLs that can be done, and the patient has frequent discomfort and is precluded from heavy lifting. This is delineated both in my current complaints section, as well as in the ADL worksheet.
>
> Q And, Doctor, are those ADL deficits not accounted for or captured in the DRE II?
>
> A That's correct.
>
> Q In your September 26, 2025, report, and then also in your supplemental report from November 23, 2025, you apply the Vigil case to add impairments for the right shoulder, the left shoulder, and the lumbar spine.
>
> Now, I'm sure, as you're aware, Doctor, the Vigil case gives two scenarios in which the combined values chart can be rebutted and alternative methods can be used for adding impairment, and it looks like you applied the second scenario, which is that there is overlap but it increases or amplifies the impacts on the overlapping ADLs; correct?
>
> A Correct.
>
> Q And in the November 23, 2025, supplemental report, you went through the specific ADLs considered under the Vigil analysis. For adding the lumbar spine to the shoulders, you pointed to a loss of lifting, cleaning house with the bending of the back, or reaching with the bilateral shoulders. Worse pain in the shoulders and back when cooking, and then carrying only medium-weight objects. Push/pull very lightweight objects.

Is that a fair summary of that reporting?

MR. MAKADA: Actually, I'm going to object. Go to the next paragraph. That's not an accurate summary. Misstates the evidence.

The next paragraph says about all the cleaning, lifting, pushing, pulling, all that. There's two paragraphs.

MR. SANTOS: I know. Did I not mention the cooking, the pushing, and pulling? I thought that was literally the last --

MR. MAKADA: All right. That's fine.

BY MR. SANTOS:

Q Okay. So, Doctor, we went through the ADL deficits that you mentioned for the application of Almaraz/Guzman, which you included was the preclusion from heavy lifting. So, correct me if I am wrong, but you used the same or similar deficits to apply – to use Almaraz/Guzman to increase the lumbar spine impairment, but also those same or similar ADLs for the application of Vigil. Did it give you any pause or make you give any further consideration for the fact that it's the same or similar basis for both of those?

A. No. As you can see, there are a number of overlap[ping] amplified functional deficits between the bilateral shoulders and the low back.

Q So you don't believe that that's an excessive increase in impairment considering that the bases for both of the increases are the same or similar?

A. No.

Q Okay. And why not?

A The Almaraz/Guzman allows for one to analogize to a separate corner of the Guides that better captures the limitations and functions, which was done. The Vigil analysis notes that in scenario 2, that if there's an amplified overlap -- if there's an overlap and it results in amplification and loss of ADLs, then one may rebut the CVC, which was applied in the Vigil analysis. So those are separate.

(Joint Exhibit 1, Deposition transcript of QME David Smolins, M.D., February 24, 2026, pp. 6-10.)

Defendant submitted a job description that was undated, unsigned, and did not appear to pertain to any particular position. It stated that the following are some of "the essential job functions that all store personnel at Hobby Lobby must be able to perform on a regular basis":

• UNDERSTAND AND COMMUNICATE ORALLY AND IN WRITING

• CHOOSE AND APPLY THE RIGHT MATHEMATICAL METHODS OR FORMULAS TO SOLVE A PROBLEM AND TO ACHIEVE TASKS

• HANDLE NORMAL OR CUSTOMARY WORK STRESSORS OR PRESSURES AND MAINTAIN AN APPROPRIATE WORK PACE

• REMEMBER INFORMATION SUCH AS WORDS, NUMBERS, PICTURES, PROCEDURES AND INSTRUCTIONS (APPLYING INSTRUCTIONS AND FOLLOWING THEM)

• ARRANGE THINGS OR ACTIONS IN A CERTAIN ORDER OR PATTERN ACCORDING TO A SPECIFIC RULE OR SET OF RULES (E.G. PATTERNS OR NUMBERS, ORDERING WEEKLY ITEMS)

• LIFT A MINIMUM OF FORTY (40) POUNDS

• CLIMB UP/DOWN LADDERS WITH A MINIMUM OF TWENTY (20) POUNDS

• LIFT OVERHEAD WHILE MOVING MERCHANDISE FROM TOP SHELVES

• REPETITIVE BENDING AND STOOPING WHILE RESTOCKING SHELVES

• PRECISELY COORDINATE MOVEMENTS OF THE FINGERS AND HANDS TO GRASP, MOVE, MANIPULATE OR ASSEMBLE OBJECTS AND HAVE ADEQUATE DEXTERITY AND STRENGTH TO COMPLETE TASKS

• STAND AND WALK FOR A MINIMUM OF EIGHT (B) HOURS, EXCLUDING BREAKS

• MULTI-TASK

• WORK IN ENVIRONMENTS THAT MAY INCLUDE DUST AND FLUCTUATING TEMPERATURES (HEAT/COLD)

• WORK IN DIFFERENT AREAS OR POSITIONS AND PERFORM TASKS IN THE STORE

• WORK OVERTIME AS NEEDED AND TO COMPLY WITH THE WORK SCHEDULE

• CONSISTENTLY BE AT WORK AND ON TIME ACCORDING TO THE WORK SCHEDULE

(Defendant's Exhibit H, p. 1, caps in original.)

At trial, applicant testified in pertinent part as follows.

He started working at Hobby Lobby in 2023 as a seasonal full-time employee. During a typical day at work he worked on the floor, put up displays, worked in the warehouse, used conveyor belts and hand trucks, put together islands, and adjusted clearance and seasonal islands. He estimated that he lifted boxes weighing between 25 to 75 pounds every day, all day, and especially while he was working in the warehouse. He unloaded trucks every Wednesday and staged and started unboxing products. He would use the hand truck to load products onto a conveyor belt to take them upstairs, where he unloaded them. He repeated this process throughout the day, either by himself or with one other person. (MOH, at pp. 5-6.)

He explained that he also assembled furniture, ornaments, and various products for different areas on the floor. He used a hand truck to bring out the products to the floor and then manually put up and took down displays. He moved metal shelves, which he estimated to weigh between 5 to 10 or 20 pounds. The shelves fit into metal brackets that together weigh 20 to 40 pounds, depending upon the number of brackets that were needed for a particular display. He also used a hand truck to move islands made of solid particleboard with plastic borders all the time, and he estimated that these weighed up to 200 pounds. It took two to three people to move an island. The island was then bolted to the floor. The islands measured approximately 6 to 8 feet by 3 to 4 feet. Setting up the island could take up to a day or two, depending upon the setup and the season. Displays changed every month and varied in accordance with the products that were placed on each island. He also set up the aisles, which measured about 30 to 40 feet long and could be 2 to 3 feet deep depending upon the displays that needed to be set up. (*Id*. at p. 6, lines 3-20.)

Applicant further explained that he split his time between working in the warehouse and working on the floor. Some days he worked the entire day in the warehouse by himself, and on other days he worked with other employees; it varied. Sometimes he set up an island by himself, and sometimes he did it with another employee. He got help moving the islands, but he usually put up the displays by himself. He set up the shelving by himself, and the weight of each shelf varied depending upon the size of the shelf. The shelves were solid metal and he estimated again that they weighed between 5 to 10 pounds. The number of shelves he put up varied with each display. He used a hand truck to move products. He felt that his job was very physical, and it involved loading, unloading, and assembly. (*Id*. at pp. 6-7.)

Applicant's job title when he was hired was “seasonal full time.” He spent at least four to five hours of his day lifting heavy items. He considers heavy to be approximately 50 pounds or more. He also considers 10 pounds to be pretty heavy. He stocked shelves every day with items such as hand towels, bath towels, candles, yarn, picture frames, storage trays, paper plates, napkins, and soap dispensers. The items he put onto the display did not all weigh the same amount. He used a hand truck, cart, and the conveyor belt when moving boxes. (*Id*. at pp.8-9.)

Over the last 30 days, he experienced pain that was on average 5 to 6 on a scale of 1 to 10, with the worst pain being approximately 8. On a good day, his pain level was 4 to 5. On average, he experiences pain for about half the day, but it varies based upon his activities. Sitting, standing, walking, and driving for too long make his pain worse. (*Id*. at p. 7, lines 4-10.)

The pain in his low back is aching and burning. Sometimes it is constant and sometimes it comes and goes. Because of this pain, he cannot do things the way he wants to, like exercise, work, or basketball training. He has to take a break after about 30 minutes to an hour of driving. He is a coach for a basketball clinic, and his pain interferes with training others. He can explain drills, but he cannot perform the drills himself. He has other coaches show how to do drills and training. He used to go to the gym and work out, but now he goes there to walk around or watch his son work out. He does not lift anymore. He uses ice and heat when he is in intense pain, which can sometimes last two to three days in a row, or occur every other day. He sometimes lies down on a mat that has plastic spikes on it to help with circulation. If his back is bothering him, he will lie down throughout the day, sometimes the entire day. (*Id*. at p. 7, lines 11-25.)

His right shoulder was in pain during trial. Over the last 30 days, his worst shoulder pain felt like a 10 on a scale of 1 to10. On a good day, it is 6 and a half out of 10. It feels like a stabbing pain, and it varies throughout the day. It is located in his shoulder and sometimes goes down his arm. The pain can be constant, or it can come and go. He cannot lift anything above his head because of the pain. The maximum he can lift with both hands is approximately 10 pounds. The maximum he can lift with his right arm only is approximately 3 to 4 pounds. He cannot lift anything above his shoulders without pain. He does not know how much he could lift above his shoulders. Activity makes his pain worse. Lying on his side while he is sleeping can also make it worse. (*Id*. at p. 8, lines 1-10.)

Over the last 30 days, his left shoulder has bothered him the same as his right shoulder. It is a sharp pain that he feels daily. The pain can vary; sometimes it is constant, and sometimes it comes and goes. He cannot lift anything above his head. Tylenol, heat, and ice make the pain better, and the pain gets worse with activity. (*Id*. at p. 8, lines 10-15.)

He recalled the QME asking him questions about his activities of daily living. He has problems with bathing, brushing his teeth, dressing, and cutting his toenails. However, he did explain to the QME all the ways that this injury has affected him. (*Id*. at p. 8, lines 15-18.)

Since the date of his injury, he has had difficulty with grocery shopping. When asked if there was a reason why he did not note that he had difficulty at the time of his deposition, he testified that he did not recall at the time. He did not recall being asked about being able to shower. At the time, he could still take a shower, but he was limited. (*Id*. at pp. 9-10.)

DISCUSSION

I

Former Labor Code[1] section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b) (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on June 9, 2026 and 60 days from the date of transmission is Saturday, August 8, 2026. The next business day that is 60 days from the date of transmission is Monday, August 10, 2026 (See Cal. Code Regs., tit. 8, § 10600(b).)[2] This decision is issued by or on Monday, August 10, 2026 so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to

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[1] Any further section references are to the Labor Code unless otherwise noted.

[2] WCAB Rule 10600(b) (Cal. Code Regs., tit. 8, § 10600(b)) states that:

> Unless otherwise provided by law, if the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

act on a petition. Section 5909(b)(2) provides that service of the WCJ's report and recommendation shall be notice of transmission.

Here, according to the proof of service of the WCJ's report and recommendation, the report was served on June 9, 2026 and the case was transmitted to the Appeals Board on June 9, 2026. Service of the report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on June 9, 2026.

II

Applicant contends that the WCJ erred by not using the QME's "*Almaraz/Guzman*" rating. Applicant further contends that the WCJ incorrectly found that his occupational group number in the PDRS is 360, and not 470.

An "*Almaraz/Guzman*" rating refers to a rating fashioned by a physician using material found within the AMA Guides in a discretionary manner that deviates from its exact instructions in order to achieve a more accurate assessment of impairment. (*Almaraz/Guzman*, *supra*, 187 Cal.App.4th 808.) The court held that (1) an employee's impairment may be determined by reference to any applicable portion of the AMA Guides, and (2) this determination may be used to rebut the rating of permanent disability established by the PDRS. The court reasoned that the language of section 4660 permits reliance on the entire AMA Guides in deriving an impairment rating in a particular case, and Chapters 1 and 2 of the AMA Guides provide instructions that permit a physician to use clinical judgment in deciding how to apply the remaining chapters. (*Id.* at p. 812.) The court noted that affording a physician some leeway in the manner of applying tables and other criteria found within the AMA Guides "does not create a new manner of calculating permanent disability or 'an exception that swallows the Schedule.' It requires application of the [AMA] Guides as written, including the instructions on its proper use." (*Id*. at p. 829.)

Thus, QME Dr. Smolins is clearly permitted to employ Table 6-9 of the AMA Guides instead of Table 15-3 as an alternative method of more accurately assessing the percentage of applicant's lumbar spine impairment. However, that opinion by itself does not constitute substantial medical evidence without adequate explanation.

All decisions of the Workers' Compensation Appeals Board must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) We have previously held en banc that "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." (*Escobedo v. Marshalls* (2007) 70 Cal.Comp.Cases 604, 620, citing *Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93]; *Place v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 372, 378-379 [35 Cal.Comp.Cases 525]; *Zemke v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal.2d 794, 798 [33 Cal.Comp.Cases 358].)

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." (*Escobedo, supra*, 70 Cal.Comp.Cases at p. 621, citing *Granado v. Workers' Comp. Appeals Bd*. (1970) 69 Cal. 2d 399, 407 [33 Cal.Comp.Cases 647] (a mere legal conclusion does not furnish a basis for a finding); *Zemke*, *supra*, 68 Cal.2d at pp. 799-801 (an opinion that fails to disclose its underlying basis and gives a bare legal conclusion does not constitute substantial evidence); *People v. Bassett* (1968) 69 Cal.2d 122, 141, 144 (the chief value of an expert's testimony rests upon the material from which their opinion is fashioned and the reasoning by which they progress from the material to the conclusion, and it does not lie in the mere expression of the conclusion; thus, the opinion of an expert is no better than the reasons upon which it is based).)

In the instant case, the QME did not provide sufficient explanation to justify choosing a 15 percent whole person impairment using Table 6-9 of the AMA Guides, which is ordinarily used to assess impairment for a hernia, instead of an 8 percent impairment under Table 15-3, which is prescribed for a diagnosis-related estimate of impairment of the lumbar spine. The only reasoning provided by Dr. Smolins in his maximal medical improvement report was that "the [AMA] Guides in their strictest sense do not accurately take into account the limitations in activities of daily living" and "one would not expect an 8% whole person impairment given the limitations in his ADLs as noted in today's reporting." (Joint Exhibit 5, p. 13.) The QME did not identify all of the affected activities of daily living from Table 1-2 of the AMA Guides; the pertinent section of his report referred only to the criteria listed in Table 6-9. No detailed reasoning was provided to justify

Dr. Smolins' conclusion that the deficits in activities of daily living were not fairly represented by an 8 percent whole person impairment, and that they more accurately corresponded with a 15 percent impairment.

The QME's supplemental report of November 23, 2025 examined activities of daily living for the purpose of establishing overlap and amplification to justify adding disabilities instead of combining them on the combined values chart in the PDRS, but the report did not provide any additional information to explain why using the hernia table to assess 15 percent whole person impairment is more accurate than using the lumbar spine diagnosis-related estimate of 8 percent. (Joint Exhibit 6, pp. 1-2.)

Unfortunately, the deposition of the QME added very little to answer these questions. Dr. Smolins noted that his worksheet listing activities of daily living included limitations on lifting and carrying, and Class 2 of Table 6-9 prescribes a range of impairment for "frequent discomfort, precluding heavy lifting, but not hindering some activities of daily living." (Joint Exhibit 1, p. 7, lines 14-17.) The QME also agreed with a leading question that those ADL deficits are not accounted for or captured in the lumbar diagnosis-related estimate (DRE) category II, but he did not explain why. (*Id*. p. 7, lines 2-25.)

While it is true that applicant carries the burden of proof to justify an *Almaraz/Guzman* rating, we "may not leave undeveloped matters which its acquired specialized knowledge should identity requiring further evidence." (*Raymond Plastering v. Workmen's Comp. Appeals Bd.* (1967) 252 Cal.App.2d 748, 753 [32 Cal.Comp.Cases 287, 291].) Here the QME provides a clear opinion that lumbar spine impairment should be 15 percent instead of 8 percent, but his explanation falls short of the standards for substantial medical evidence. Under these circumstances, the constitutional mandate to accomplish substantial justice requires the Appeals Board to use its power to develop the record to seek clarification rather than speculatively assume that the QME's conclusion is incorrect. (See Cal. State Const., Art. XIV, § 4; Lab. Code, § 5701.) We therefore will defer the issue of permanent disability so that the record can be developed on the disputed issue of the QME's proposed *Almaraz/Guzman* rating. Additional medical evidence should be obtained from Dr. Smolins, the QME who has already reported in this case. (See *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2002) 67 Cal.Comp.Cases 138 (Appeals Board en banc).)

This development of the record will also afford the WCJ the opportunity to consider further the issue of applicant's occupational group number. The group number selected by the WCJ, 360, appears to be a compromise between the number requested by defendant, 214, and the number requested by applicant, 470. While group number 360 may indeed be the best reflection of applicant's actual job duties, the WCJ may want to take this opportunity to develop the record to address deficits in the evidence that was offered by both sides on this issue, as noted in her Report. Defendant's list of job duties is not comprehensive, offering a list of just "some" of the essential job functions for all personnel. Applicant's trial testimony is likewise problematic, based on an imperfect recollection. We note that applicant's testimony at trial does provide some guidance as to the weight associated with lifting while working in the warehouse, because he testified that he "lifted boxes weighing between 25 to 75 pounds every day. He estimates that he lifted consistently all day, especially while working in the warehouse." (MOH, p. 5, lines 23-25.)

Accordingly, we will grant applicant's Petition, rescind the May 14, 2026 F&A and substitute a new F&A that defers the issues of permanent disability and occupational group number and return the matter for further proceedings consistent with this opinion.

For the foregoing reasons,

IT IS ORDERED that applicant's Petition for Reconsideration of the Findings of Fact and Award issued by the WCJ on May 14, 2026 is **GRANTED**.

IT IS FURTHER ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the May 14, 2026 Findings of Fact and Award is **RESCINDED** and the following is **SUBSTITUTED** therefor:

FINDINGS OF FACT

1. Lawrence Thompson, while employed on April 14, 2023, as a Stockman/Retail Laborer at Sacramento, California by Hobby Lobby Stores, sustained injury arising out and in the course of employment to his low back and shoulders.

2. At the time of injury, the employer's workers' compensation carrier was ACE American Insurance Company, administered by Sedgwick CMS.

3. At the time of injury, applicant's earnings were $703.46 per week, warranting indemnity rates of $468.98 for temporary disability and $290.00 for permanent disability.

4. Defendant has paid compensation as follows: Temporary disability indemnity at the weekly rate of $468.98 for the periods of April 19, 2023 to April 20, 2023, and July 16, 2023 to July 9, 2025 and permanent disability indemnity at the weekly rate of $290.00 commencing on July 10, 2025 to the present.

5. Applicant is entitled to further medical treatment.

6. The issues of permanent disability and attorney's fees are deferred.

7. The issue of applicant's occupational group number is deferred.

AWARD

AWARD IS MADE in favor of Lawrence Thompson against ACE American Insurance Company of future medical care reasonably required to cure or relieve the effects of the industrial injury.

IT IS FURTHER ORDERED that the matter is **RETURNED** to the WCJ for further proceedings consistent with this decision.

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG L. SNELLINGS, COMMISSIONER

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

AUGUST 10, 2026

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

LAWRENCE THOMPSON
LAW OFFICES OF NADEEM H. MAKADA
LLARENA, MURDOCK, LOPEZ & AZIZAD, APC

CWF/*cs*

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

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

MANUEL NATIVIDAD COBOS, *Applicant*

vs.

CARDENAS MARKETS, LLC; SAFETY NATIONAL CASUALTY, administered by SEDGWICK, *Defendants*

Adjudication Number: ADJ14079246
San Francisco District Office

OPINION AND DECISION AFTER RECONSIDERATION

The Appeals Board previously granted reconsideration in this matter to provide an opportunity to further study the legal and factual issues raised by the Petition for Reconsideration. Having completed our review, we now issue our Decision After Reconsideration

Applicant seeks reconsideration of the Findings of Fact and Award (F&A) of April 10, 2023, wherein the worker compensation judge (WCJ) found in pertinent part that applicant, while employed by defendant on June 23, 2018 as a butcher, sustained injury arising out of and in the course of employment (AOE/COE) to his right shoulder and neck; and that applicant's injury caused 26% permanent disability.

Applicant contends that the WCJ erred when she found that he had 5% whole person impairment (WPI) of his right shoulder based on the scheduled rating; and that the WCJ should have found that applicant had 17% WPI based on the opinion of the Agreed Medical Evaluator (AME) Dr. Peter Mandell.

We have received an Answer from defendant. The WCJ prepared a Report and Recommendation on Petition for Reconsideration and (Report), recommending that the Petition be denied.

We have considered the Petition for Reconsideration, the Answer, and the contents of the Report, and we have reviewed the record in this matter. For the reasons discussed below, as our

Decision After Reconsideration, we will rescind the F&A and return this matter to the trial level for further proceedings.

FACTS

Applicant sustained injury AOE/COE to his right shoulder and neck while working as a butcher for defendant on June 23, 2018. Applicant was in the cooler at work when some boxes fell and hit him on the neck and right shoulder. On July 19, 2019, primary treating physician (PTP) Dr. William Campbell, D.O. performed surgery on applicant's right shoulder. (Jt. Ex. 6, Surgical Report of William Campbell, D.O., dated 7/19/19, pp. 1-2.)

The AME Dr. Mandell submitted two reports. In his report of July 21, 2021, Dr. Mandell reported that applicant's surgery helped a little bit, that he did some physical therapy, and that he was off work for eight months. (Jt. Ex. 2, Report of Peter Mandell, M.D., dated 7/21/21, pp. 1-3.) He has since resumed work full-time. (Jt. Ex. 2, p. 7.) Dr. Mandell found applicant to be permanent and stationary. (Jt. Ex. 2, p. 7.) Dr. Mandell found that applicant had an 8% WPI for his neck. (Jt. Ex. 2, p. 7.) Dr. Mandell provided the following analysis for applicant's shoulder:

> For his RIGHT shoulder, under the strict AMA Guides criteria, he has the following active ranges of motion:
>
> - 140° of abduction for a 2% upper extremity impairment.
> - 130° of forward flexion for a 3% upper extremity impairment.
> - 45° of external rotation for a 1% upper extremity impairment.
> - 45° of extension for a 1% upper extremity impairment.
> - 35° of adduction for a 1% upper extremity impairment.
>
> That adds to an 8% upper extremity impairment or a ***5% whole person impairment***.
>
> Approximately 100% of the causation of his shoulder impairment is a direct result of the injury in question.
>
> He will need treatment in the form of injections, medications, and physical therapy. He may even require additional surgery, and provision should be made for that.
>
> Under *Guzman*, the neck impairment is accurate. The shoulder impairment is not because, while it takes into account range of motion loss, it doesn't take into account grip strength loss. To correct for that, I turn to Table 16-31 on page 509 and note that an average male major grip strength is 47.6 kg. His best effort was 28.9 kg. Applying the strength loss index formula produces a 39% strength loss index, which from Table 16-34 is a 20% upper extremity impairment or 12% whole person impairment. I would add that to the above for a total of ***17% whole person***

impairment. That's the accurate rating here based on my training, experience, judgment, and skill and offered with reasonable medical probability.

He can continue working full-time and full duty and is not in need of supplemental job displacement benefits.

(Jt. Ex. 2, pp. 7-8, emphasis in original.)

In his report of September 25, 2021, Dr. Mandell stated the following:

You ask whether or not there was a separate etiology for grip strength loss in Mr. Natividad Cobos' RIGHT upper limb except for the shoulder. The answer to that is not that I know of. I can tell the parties that for many years now I have evaluated hundreds if not thousands of individuals with shoulder problems and the vast majority of them had grip strength loss because of the interaction between the shoulder, elbow, wrist, forearm, and hand. Grip strength, in my medically probable opinion, does describe accurately what Mr. Natividad Cobos has to live and work with every day in the course of his activities and does represent an accurate assessment of his impairment.

You then go on to note that when adjusted for age and occupation, Mr. Natividad Cobos' disability turns out to be 41% whole person impairment. You then ask whether or not a 41% impairment accurately represents the disability Mr. Natividad Cobos has, even though he's back at full duty. I can only talk about the scientific and medical aspects of what I saw in Mr. Natividad Cobos' case. From a medical and scientific perspective, 17% whole person impairment is accurate. If there are other things at play here from a legal perspective, I would certainly defer to the lawyers and judges to hash that out.

(Jt. Ex. 1, Report of Peter Mandell, M.D., dated 9/25/21, pp. 1-2.)

The case proceeded to trial on March 9, 2023. The parties stipulated to a rating for applicant's neck resulting in 17% permanent disability. (Minutes of Hearing (MOH), p. 2, Stipulation 6.) As relevant here, the issue was:

1. What is the accurate permanent disability rating for the right shoulder?

Defense argues that the strict rating of 5% whole person impairment, rating out to 11% PD, using the range of motion method in the AMA Guides, is the most accurate reflection of applicant's permanent disability to his right shoulder.

Applicant argues that the whole person impairment of 17% as set forth in Dr. Mandell's Guzman rebuttal analysis is the more accurate whole person impairment. This would rate out to 37% permanent disability for the right shoulder.

(MOH, p. 2.)

The WCJ issued the F&A on April 10, 2023, finding in relevant part that applicant had sustained injury AOE/COE to his right shoulder and neck while employed by defendant on June 23, 2018; that applicant's level of permanent disability was 26%; and that there was a need for future medical treatment to cure or relieve the effects of the industrial injuries. The WCJ awarded applicant permanent disability of 26%, less attorney's fees; 15% of the permanent disability award as attorney's fees to applicant's attorney, the exact amount to be adjusted by the parties; future medical treatment; and deferred all other issues.

DISCUSSION

The workers' compensation system includes compensation for permanent disability. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320.) "'[P]ermanent disability is understood as 'the irreversible residual of an injury.'" (*Id*. at p. 1320, quoting *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1111.) "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*, *supra*, at p. 1320, citing Lab. Code, § 4660(a).)

When assessing an injured employee's permanent disability, the first step is a comprehensive medical-legal report prepared by a treating or evaluating physician. (*Blackledge v. Bank of America* (2010) 75 Cal.Comp.Cases 613, 619.) The physician uses the AMA Guides to determine the WPIs for the applicant's medical conditions. (*Id*. at pp. 619-620.) The physician must set forth their reasoning behind the WPI. (*Id*. at p. 621.) "The expert opinion of a single physician may establish an injured employee's WPI, provided that the opinion constitutes substantial evidence. (*Id*. at p. 620, citing *Place v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 372, 378–379 [35 Cal.Comp.Cases 525, 529-539].) Permanent disability payments are then calculated by converting that degree of permanent disability into an award based on a table. (*Department of Corrections & Rehabilitation v. Workers' Comp. Appeals Bd.* (*Fitzpatrick*) (2018) 27 Cal.App.5th 607, 611 [83 Cal.Comp.Cases 1680], citing *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1270 [76 Cal.Comp.Cases 624].)

If a formal rating is requested, the WCJ's role is to frame instructions, based on substantial medical evidence, that specifically and fully describe the whole person impairment(s) to be rated, and the rater's role is to issue a recommended permanent disability rating based solely on the WCJ's formal rating instructions. (*Blackledge*, *supra*, 75 Cal.Comp.Cases at p. 615.) A WCJ is

not bound by a rater's recommended permanent disability rating, and instead the WCJ may choose to independently rate an applicant's permanent disability. (*Id*. at p. 616.) However, the WCJ's rating must be based on substantial evidence. (*Id*. at p. 616.)

Nevertheless, the scheduled rating under the PDRS (Permanent Disability Rating Schedule) can be rebutted. (*Fitzpatrick*, *supra*, 27 Cal.App.5th at p. 619.)

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

(*Ogilvie*, *supra*, 197 Cal.App.4th at p. 1277.)

In *Almaraz v. Environmental Recovery Services* (2009) 74 Cal.Comp.Cases 1084 (Appeals Bd. en banc) (*Almaraz II*), we held that a "scheduled permanent disability rating may be rebutted by successfully challenging the component element of that rating relating to the employee's WPI under the AMA Guides….by establishing that another chapter, table, or method within the four corners of the Guides most accurately reflects the injured employee's impairment." (*Id*. at pp. 1095-1096.) In *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (*Guzman*) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837], the Court of Appeal affirmed our decision in *Almaraz II*.

In the instant case, AME Dr. Mandell concluded that "under the strict AMA Guides criteria," applicant has an 8% upper extremity impairment or a 5% WPI. (Jt. Ex. 2, pp. 7-8.) However, he concluded that applicant's shoulder impairment was not accurate, because

> while it takes into account range of motion loss, it doesn't take into account grip strength loss. To correct for that, I turn to Table 16-31 on page 509 and note that an average male major grip strength is 47.6 kg. His best effort was 28.9 kg. Applying the strength loss index formula produces a 39% strength loss index, which from Table 16-34 is a 20% upper extremity impairment or 12% whole person impairment. I would add that to the above for a total of ***17% whole person impairment***. That's the accurate rating here based on my training, experience, judgment, and skill and offered with reasonable medical probability.

(Jt. Ex. 2, p. 8.)

Dr. Mandell further explained his reasoning in his later report:

> I can tell the parties that for many years now I have evaluated hundreds if not thousands of individuals with shoulder problems and the vast majority of them had grip strength loss because of the interaction between the shoulder, elbow, wrist, forearm, and hand. Grip strength, in my medically probable opinion, does describe accurately what Mr. Natividad Cobos has to live and work with every day in the course of his activities and does represent an accurate assessment of his impairment.

(Jt. Ex. 1, pp. 1-2.) Dr. Mandell confirmed his conclusion that using the AMA Guidelines strict criteria did not accurately reflect applicant's WPI and stated "From a medical and scientific perspective, 17% whole person impairment is accurate." (Jt. Ex. 1, p. 2.)

However, the WCJ did not follow Dr. Mandell's conclusions and determined that the WPI for the shoulder should be 5%, with a permanent disability rating of 11% and therefore applicant's permanent disability rating, including both the neck and right shoulder, was 26%. (Opinion on Decision (OOD), pp. 4-6; F&A, pp. 1-2.) The WCJ stated that Dr. Mandell's alternative rating might be viable under other circumstances. (OOD, pp. 4-6.) The WCJ explained that Dr. Mandell's use of grip strength was incorrect for an injury above the elbow and that the correct table for applicant's injury was 16-35 on page 510 of the AMA Guidelines. (OOD, pp. 4-6.)

Since the WCJ rejected the AME's grip strength analysis, the WCJ should have sought further clarification from Dr. Mandell. Dr Mandell's explanation does not address the how and why a metric designed for the below the elbow upper extremity injuries (grip strength) was used instead of the standard interpretation in the AMA Guidelines for a shoulder injury. Dr. Mandell's reports are the only medical evidence on this issue. There is also a lack of substantial medical evidence to support the use of the table identified by the WCJ. (See *Blackledge*, *supra*, 75 Cal.Comp.Cases at p. 616.)

Decisions of the Appeals Board must be based on substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) A medical opinion must be framed in terms of reasonable medical probability, it must be based on an adequate examination and history, it must not be speculative, and it must set forth reasoning to support the expert conclusions reached. (*E.L. Yeager Construction v. Workers' Comp. Appeals Bd. (Gatten)* (2006) 145 Cal.App.4th 922, 928 [71 Cal.Comp.Cases 1687]*; Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 620-621 (Appeals

Bd. en banc).) "Medical reports and opinions are not substantial evidence if they are known to be erroneous, or if they are based on facts no longer germane, on inadequate medical histories and examinations, or on incorrect legal theories. Medical opinion also fails to support the Board's findings if it is based on surmise, speculation, conjecture or guess." (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].)

On the other hand, there must be some solid basis in the medical report for the doctor's ultimate opinion; the Appeals Board may not blindly accept a medical opinion which lacks a solid underlying basis and must carefully judge its weight and credibility. (*National Convenience Stores v. Workers' Comp. Appeals Bd.* (*Kesser*) (1981) 121 Cal.App.3d 420, 426 [46 Cal.Comp.Cases 783].) In other words, the Appeals Board must look to the underlying facts of a medical opinion to determine whether or not that opinion constitutes substantial evidence, and accordingly, the expert's opinion is no better than the facts on which it is based. (*Turner v. Workers' Comp. Appeals Bd.* (1974) 42 Cal.App.3d 1036, 1044 [39 Cal.Comp.Cases 780].)

The issue we face on appeal is that we do not have the necessary medical evidence to support either Dr. Mandell's or the WCJ's conclusion regarding applicant's WPI of his right shoulder. The WCJ and the Appeals Board both have a duty to develop the record further where there is an absence of or insufficient evidence to determine the issues raised for trial. (*Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal. App.4th 389, 393-395 [62 Cal.Comp.Cases 924]; *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117, 1121-1122 [63 Cal.Comp.Cases 261]; see Lab. Code, §§ 5701 and 5906; *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2001) 67 Cal.Comp.Cases 138, 139 (Appeals Bd. en banc).) Indeed, the Appeals Board has a constitutional mandate to "ensure substantial justice in all cases," and is therefore "clearly permitted" to admit evidence even after the discovery cut-off under section 5502(d)(3). (*Kuykendall v. Workers' Comp. Appeals Bd.* (2000) 79 Cal.App.4th 396, 403-405 [65 Cal.Comp.Cases 264].) "[A]llowing full development of the evidentiary record to enable a complete adjudication of the issues is consistent with due process in connection with workers' compensation claims" and militates in favor of our presuming the continued vitality of sections 5701 and 5906, absent a clear legislative intention to the contrary." (*Tyler*, *supra*, 56 Cal.App.4th at p. 394.) An adequately developed record affords all parties due process of law and further provides for meaningful review by the Appeals Board of a WCJ's decision. (*Evans v. Workers'*

Comp. Appeals Bd. (1968) 68 Cal.2d 753, 755 [33 Cal.Comp.Cases 350]; *Hernandez v. Staff Leasing* (2011) [76 Cal.Comp.Cases 343, 346-347] (Appeals Bd. significant panel decision).)

Therefore, as there is a lack of substantial evidence to support either Dr. Mandell's or the WCJ's conclusions as to the WPI in applicant's right shoulder, as our Decision After Reconsideration, we rescind the F&A and return this matter to the trial level for further proceedings consistent with this decision.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the April 10, 2023 Findings of Fact and Award is **RESCINDED** and that the matter is **RETURNED** to the trial level for further proceedings consistent with this opinion.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER

/s/ CRAIG L. SNELLINGS, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MAY 26, 2026

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

MANUEL NATIVIDAD COBOS
WYMAN & HEGWER
FINNEGAN, MARKS, DESMOND & JONES

JMR/*pm*

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

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

PING HUNG LI, *Applicant*

vs.

MODERN CONSTRUCTION, INC.
FALLS LAKE FIRE AND CASUALTY COMPANY, administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., *Defendants*

Adjudication Numbers: ADJ14149688, ADJ21878559
San Francisco District Office

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION

Defendant seeks reconsideration of the Joint Findings, Award, and Orders (F&A) issued on April 24, 2026. The workers' compensation administrative law judge (WCJ) found, in relevant part, that in ADJ14149688 applicant sustained injury to his cervical spine and lumbar spine and applicant did not meet his burden of proof that he sustained injury arising out of and in the course of employment to the excretory system, bilateral upper extremities and bilateral lower extremities; in ADJ21878559 applicant did not meet his burden of proof that he sustained injury to the excretory system, spine, neck, bilateral upper extremities, and bilateral lower extremities during the period of February 3, 2020 through December 2, 2025; that applicant's condition was permanent and stationary on August 9, 2023; defendant did not meet its burden of proof that it is entitled to credit for overpayment of temporary disability for the period of March 6, 2021 through February 8, 2022; applicant's injury caused permanent disability of 44%; and that defendants are entitled to a credit in the amount of $5,600 for applicant's third party recovery.

Defendant contends that the WCJ erred by finding industrial injury and impairment to the cervical and lumbar spine, that the impairment utilized by the WCJ is not supported by substantial medical evidence, and that the Qualified Medical Evaluator (QME)'s final opinion on impairment, based on an "Almarez/Guzman" analysis, should be followed.

Applicant filed a response. The WCJ issued a Report and Recommendation (Report) recommending denial of the Petition.

Defendant filed a supplemental Petition contesting the WCJ's opinion that QME reports that discuss excluded sub rosa footage should be excluded from the record, thereby further supporting the finding of impairment from prior reports. Defendant alleges that the sub rosa footage, despite being unauthenticated, was sent by agreement between the parties. We accept and consider the supplemental Petition under our authority in WCAB Rule 10964 (Cal. Code Regs., tit. 8, § 10964).

We have considered the allegations of the Petition, the Answer, the supplemental Petition, and the contents of the Report of the WCJ. Based on our review of the record, and for the reasons stated below, we will grant reconsideration, rescind the WCJ's decision, and return this matter to the WCJ for further proceedings consistent with this decision. This is not a final decision on the merits of any issues raised in the petition and any aggrieved person may timely seek reconsideration of the WCJ's new decision.

FACTS

On January 22, 2021, applicant filed an Application for Adjudication of Claim (Application) alleging a specific injury on February 3, 2020 to the right hand, right clavicle, excretory system, spine, neck, bilateral upper extremities, and bilateral lower extremities. Applicant was a passenger in a motor vehicle collision.

On December 2, 2025, applicant filed a second Application, alleging cumulative injury from February 3, 2020 through December 2, 2025 to the excretory system, spine, neck, bilateral upper extremities, and bilateral lower extremities.

Applicant's current primary treating physician is Timothy Lo, M.D. Applicant began seeing Dr. Lo on November 9, 2022. (Applicant's Exhibit 1.) Dr. Lo took a history that applicant was involved in a motor vehicle accident in which he was the front row passenger when another vehicle struck the passenger side of the car. In this initial evaluation, applicant reported that he was unable to raise his right arm without help of the left arm, used a quad cane due to right sided weakness in his leg, had depression, and right side neck pain that radiated through the entire right side of his body and face. On physical examination, he had an antalgic gait, weakness, atrophy of the right calf at about 1 cm less than the left. He had significant atrophy in the right upper arm and forearm, with redness in the distal right hand with swelling. He could not lift his arm more than

five degrees with significant discomfort. He had tenderness and limitation in the right rotation of the head limited to 30 degrees. (*Id*. at p. 5.) Dr. Lo stated:

> "[Applicant] clearly has significant objective evidence of injury and the possibility of brachial plexopathy or spinal cord injury is possible. Electrodiagnostic studies typically will not detect cervical spinal cord injury and brachial plexopathy is frequently difficult to diagnose with electrodiagnostic studies. He had findings of right ulnar neuropathy, late on findings of carpal tunnel syndrome, and then subsequently polyneuropathy of the right upper extremity, which would be consistent with the difficulty in diagnosing brachial plexopathy through electrodiagnostic testing."

(*Id.* at p. 6.)

On November 30, 2022, applicant was seen for a QME evaluation by James Chen, M.D. (Defendant's Exhibit Q.) At this evaluation, applicant complained of pain to his right shoulder, neck, and low back. Dr. Chen reviewed and summarized medical records. He noted that on physical evaluation, the range of motion and motor testing of the cervical and lumbar spine were deferred due to pain, and sensation was intact to all cervical and lumbar dermatomes. The right shoulder was tender, but range of motion was also deferred due to pain. Dr. Chen diagnosed 1. Cervical strain with radiculopathy; 2. Right sternoclavicular joint subluxation; 3. Lumbar strain with radiculopathy; 4. Right shoulder rotator cuff tear post-surgery. (*Id*. at pp. 32 and 33.) He found all injury industrially caused and did not find applicant to be MMI. He recommended continued physical therapy and pain management. (*Id*. at p. 34.)

On July 12, 2023, applicant had another evaluation with QME Dr. Chen. (Defendant's Exhibit S.) At this evaluation, applicant noted that physical therapy was denied by the carrier and that he underwent acupuncture on his own. His pain was worse. (*Id*. at p. 2.) Again, on examination, the QME noted tenderness in the cervical spine, right shoulder, and lumbar spine but other testing could not be completed due to pain. (*Id*. at p. 4.) The diagnoses remained the same. Despite being unable to complete testing, he found applicant at MMI. He provided 8% impairment for the cervical spine based on a DRE II. There was no further explanation for this placement or rating. For the lumbar spine he also designated 8% for DRE II. For the right shoulder he provided 6% whole person impairment based only on the distal clavicle resection. (*Id*. at p. 5.) He also added 3% whole person impairment for pain without explanation. No chapters, charts, or page numbers from the AMA Guides were noted in the report.

On January 8, 2024, QME Dr. Chen was deposed by defendants. (Defendant's Exhibit W.) He admitted that because applicant stated that he had pain, he did not perform the testing because applicant stated he had pain and not because applicant refused to participate. (*Id*. at 19:13-24.) He also stated that where a patient is in pain, range of motion and strength testing will not be valid. (*Id*. at 20:2-5.) They discuss applicant's deposition testimony in which he stated he was basically paralyzed and without sensation on the right side. He opined at one point that the medical record does not support those complaints and that it would not change his impairment ratings. (*Id*. at 25:2-26:1.) He also opined that the abnormal nerve conduction studies were not due to applicant's diabetes. (*Id*. at 32:4-15.) They discussed the finding of carpal tunnel syndrome and the QME concluded that carpal tunnel would not be the result of the specific motor vehicle accident. (*Id*. at 33:24-34:2.) The remainder of the deposition included hypothetical questions and a request for the QME to review any additional discovery to include an additional deposition and surveillance.

On June 13, 2024, applicant was seen by PTP Dr Lo. (Applicant's Exhibit 5.) He presented with a quad cane in left hand and was given transportation for the appointment. On examination, there was weakness in the distal and proximal right lower extremity. He was unable to lift his right arm without the assistance of his left hand for right shoulder flexion and abduction. Mild swelling was noted in the right upper extremity. He could not lift the (non-specific) lower extremity to test strength. (*Id.*) Diagnoses were cervical disc disorder with myelopathy, brachial plexus disorder, chronic pain syndrome, adjustment disorder with mixed anxiety and depressed mood.

In Dr. Lo's report dated February 4, 2025, he noted that applicant was unable to ambulate alone as he uses a four-point cane on his left side and must have a person walk with him to support the left side as he drags his right leg and right arm does not swing. Physical exam of the right side revealed remarkable weakness. Dr. Lo requested an electric wheelchair. (*Id.* at p. 11.)

On September 26, 2024, the parties proceeded to a status conference, and trial was set on the issue of discovery to determine the authenticity of sub rosa footage and whether the film could be sent to the QME.

The parties proceeded to trial on April 14, 2025 on the issue of "authenticity of the sub rosa video, including whether it was applicant depicted on the video on the dates of the video and whether the sub rosa is to be sent to panel selected QME." (MOH/SOE, 04/14/2025, 2:24-27.) Surveillance taken on March 6, 2021, May 2, 2023, and May 3, 2023 (Defendant's Exhibits D, E,

F) were reviewed.[1] Applicant and his son testified. The matter was continued for further testimony, however thereafter, the parties agreed there was no further testimony, and the matter was submitted on May 27, 2025.

On July 8, 2025, the WCJ issued a Findings of Fact and Order finding, in relevant part, that Defendant's Exhibit D, surveillance dated March 6, 2021, was not properly authenticated, but that Exhibits E and F, surveillance on May 2 and 3, 2023, were properly authenticated and that applicant is identified in the surveillance, and that Defendant's Exhibits E and F were relevant to warrant submission to the QME for comment. The WCJ ordered Defendant's Exhibits E and F to be submitted to the QME. There was no objection or removal filed to this F&O.

On October 29, 2025, Dr. Chen evaluated applicant again. (Defendant's Exhibit T.) For this evaluation, he reviewed one additional report from Dr. Lo dated September 8, 2025 as well as the depositions of applicant and all three dates of surveillance, despite the F&O. (*Id*. at p. 5.) At the evaluation, applicant was seated in the motorized scooter and stated that he was unable to get up from a seated position. Again, the testing was deferred due to pain. Range of motion testing was attempted for the right shoulder, but he stated he could not move his right shoulder, so the testing was deferred. The diagnoses were right shoulder rotator cuff tear status post-surgery, cervical strain, and lumbar strain. (*Id*. at p. 7.) Dr. Chen stated, "I continue to opine that Mr. Li sustained injuries to his cervical spine, lumbar spine, and right shoulder that were industrial in causation." (*Id*.) However, after reviewing the surveillance he stated,

> I would therefore utilize the latitude afforded by the Almarez/Guzman decisions and revise his cervical spine and lumbar spine impairment ratings to zero percent whole person based on the range of motion and comfort as visualized in the video surveillance footage. I would also amend the pain add-on impairment to zero percent whole person impairment.

(*Id*. at p. 7.)

He continued to opine that applicant had 6% whole person impairment for the shoulder due to the shoulder surgery. He also released applicant to full duty work.

On December 5, 2025, Dr. Chen issued a supplemental report. (Defendant's Exhibit T.) In this report, he amended the permanent and stationary date to "at or before" the March 6, 2021 surveillance video. He also stated that applicant is not in need of future medical treatment for his

[1] These exhibits were not in EAMS, so we could not review them independently.

cervical spine and lumbar spine, adding that any treatment after the March 6, 2021 surveillance would be non-industrial. In regard to the change of opinion on impairment and treatment he stated:

> These videos change my opinion regarding Mr. Li's level of impairment because I consider them substantial medical evidence that Mr. Li's level of function is much higher than he reported. The surveillance videos show a high level of function that is not consistent with his presentations to his health care providers. The video surveillance of March 6, 2021 shows the applicant comfortably smoking outside of his home, getting in and out of a car, standing in line at an ATM machine, walking and rubbing his hands. I reviewed the video surveillance on May 2, 2023 of the applicant getting into and out of a car, entering and exiting a home all appearing very comfortable and in no distress.

(*Id.* at p. 2.)

On December 9, 2025, Dr. Chen issued another supplemental report responding to defense counsel's request that he opine as to whether there is a cumulative injury. (Defendant's Exhibit U.) He found that there was no evidence of a cumulative injury because there were no prior records to suggest prior injury or ongoing complaints. He opined that he did not need to evaluate applicant for a new cumulative injury given the number of times he had already seen applicant. (*Id*. at p. 3.)

On December 18, 2025, defendant filed a Declaration of Readiness to Proceed (DOR) to a Mandatory Settlement Conference (MSC) stating, "Applicant's attorney has alleged a CT claim citing a specific claim. PQME has already addressed this alleged mechanism of injury. Defendants dispute entitlement to additional panels." The MSC was set for February 11, 2026, and the matter was set for trial on all disputed issues.

On March 16, 2026, the parties proceeded to trial. The issues in ADJ14149688 were:

> 1. Parts of body, with applicant claiming injury to the excretory system, spine, neck, bilateral upper extremities, and bilateral lower extremities.
> 2. Permanent and stationary date, with the applicant contending his condition is not permanent and stationary, and the employer claiming March 6, 2021, based on the reporting of Dr. Chen in his December 9, 2025, report.
> 3. Permanent disability and apportionment.
> 4. Need for further medical care.
> 5. Attorneys' fees.
> 6. Defendants' petition for credit for overpayment of temporary disability in the amount of $26,653.72 for the period of March 6, 2021 through February 8, 2022.

(MOH/SOE, 3:3-20.)

In ADJ21878559, the only issue was "injury arising out of and in the course of employment." (*Id*. at 4:3.)

Applicant testified that following surgery his condition got worse to the point where he could not move his right arm and has pain in his neck. (MOH/SOE, 6:22-25.) He recalled seeing QME Dr. Chen on three occasions. The first time, he took measurements, but the second and third time he did not. (*Id*. at 6:27-33.) He testified that he told Dr. Chen there was video, but that Dr. Chen did not ask any questions about the video. (*Id.* at 6:35-37.) On cross examination, applicant testified that at the second evaluation he attempted to lift his right arm but was unable to so Dr. Chen helped push it up which caused pain in the shoulder and neck, but his arm has no feeling. (*Id*. at 6:45-7:3.) His deposition testimony was reviewed and applicant confirmed that from the tip of his shoulder to his fingertips he had no feeling, yet he does have pain in the neck and shoulder. (*Id*. at 7:5-16.) He added that his back and left thigh were hurting but not the right. (*Id*. at 7:32-24.) He did not recall who Dr. Timothy Lo was. (*Id*. at 7:36-40.)

Applicant testified that he cannot lift his arm but can move it slightly. (*Id*. at 8:15-19.) During physical therapy at that time, they were using electrical equipment which helped his arm to move some. He stated he does not have feeling in his right arm, but "if they use medical devices to poke on it, he will have feeling." (*Id.* at 8:25-32.) He also testified that he cannot walk without a cane or a walker as he has no sensation or strength in the right leg. He does not walk alone at home. (*Id*. at 9:18-24.) He stated that he had no feeling in his right arm or leg. (*Id*. at 9:31-35.)

The F&A issued on April 24, 2026. As relevant here, the WCJ found that applicant sustained injury to the cervical and lumbar spine, did not sustain compensable injury to the excretory system, bilateral upper extremities and bilateral lower extremities, and did not meet the burden to prove a cumulative injury from February 3, 2020 through December 2, 2025. The WCJ also found that the MMI date was August 9, 2023, that defendant did not meet its burden to prove a temporary disability over payment for the period of March 6, 2021 through February 8, 2022, and that applicant's injury caused permanent disability of 44%.

The WCJ opined that the only evaluator to comment on cumulative injury was Dr. Chen who found in his December 9, 2025 report that there was no evidence to support a cumulative injury. Likewise, no physician commented on causation for injury to the excretory system, upper extremities apart from the right shoulder, or lower extremities. She noted that the right hip and

right lower extremities were mentioned as diagnoses at various points by Dr. Lo, but causation was never discussed.

The WCJ disagreed that Dr. Chen's ultimate finding that MMI was reached prior to the March 6, 2021 surveillance was flawed because applicant had surgery after that date and therefore could not be MMI. Thus, the WCJ opined that August 9, 2023, the original date of the MMI report was the proper date.

Finally, for impairment the WCJ opined that Dr. Chen's *Almarez/Guzman* rating was not supported and was not substantial medical evidence. Though she did not find applicant credible at either the first trial or this trial, the medical opinion did not adequately address why the activity on the surveillance was inconsistent with the assignment of DRE II impairment for both the cervical and lumbar spine. Likewise, the WCJ opined that the QME's opinion that applicant was not entitled to medical care for the cervical and lumbar spine was an impermissible attempt to apportion medical treatment.

In response to defendant's Petition, the WCJ issued a Report affirming the opinion, but also noting that the March 6, 2021 surveillance was deemed unauthenticated and should not have been sent to the QME. As a result, all reports after receipt of the excluded surveillance are not substantial medical evidence.

DISCUSSION

I.

Former Labor Code section 5909[2] provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

[2] All further statutory references will be to the Labor Code unless otherwise indicated.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on May 27, 2026 and 60 days from the date of transmission is Sunday, July 26, 2026. The next business day that is 60 days from the date of transmission is Monday, July 27, 2026. (See Cal. Code Regs., tit. 8, § 10600(b).)[3] This decision issued by or on Monday, July 27, 2026 so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Section 5909(b)(2) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on May 27, 2026 and the case was transmitted to the Appeals Board on May 27, 2026. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the Report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on May 27, 2026.

II.

It is well established that decisions by the Appeals Board must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal. Comp. Cases 310]; *LeVesque v. Workmen's Comp. Appeals Bd*. (1970) 1 Cal.3d 627 [35 Cal. Comp. Cases 16].) "The term 'substantial evidence' means evidence which, if true, has

[3] WCAB Rule 10600(b) (Cal. Code Regs., tit. 8, § 10600(b)) states that:

> Unless otherwise provided by law, if the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion … It must be reasonable in nature, credible, and of solid value." (*Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566], emphasis removed and citations omitted.) To constitute substantial evidence "… a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).) Where the medical evidence or opinion on an issue is incomplete, stale, and no longer germane, or is based on an inaccurate history, or speculation, it does not constitute substantial evidence. (*Place v. Workers' Comp. Appeals Bd*. (1970) 3 Cal.3d 372 [35 Cal.Comp.Cases 525]; *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 621.)

In this matter, we do not agree that any of the QME reporting upon which the F&O is based is substantial medical evidence. Beginning first with the reports following review of the surveillance, the opinions regarding permanent disability, future medical treatment, and maximum medical improvement are not supported by the record.

In *Almaraz v. Environmental Recovery Services* (2009) 74 Cal.Comp.Cases 1127 (Appeals Bd. en banc) (commonly known as, and hereinafter referred to as *Almaraz II*), we held that a "scheduled permanent disability rating may be rebutted by successfully challenging the component element of that rating relating to the employee's WPI under the AMA Guides….by establishing that another chapter, table, or method within the four corners of the Guides most accurately reflects the injured employee's impairment." (*Almaraz II*, 74 Cal.Comp.Cases at pp. 1095-1096.) In *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (*Guzman*) *(2010)* 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837], the Court affirmed our decision in *Almaraz II*.

In order for an applicant to prevail on this whole person impairment (WPI) assigned under *Almaraz II*, additional evidence is necessary: The doctor is expected to 1) provide a strict rating per the AMA Guides, 2) explain why the strict rating does not accurately reflect the applicant's disability, 3) provide an alternative rating using the four corners of the AMA Guides, and 4) explain why that alternative rating most accurately reflects applicant's level of disability. (*Id*. at pp. 828-829.)

Here, the QME, in support of rebutting the strict AMA ratings for the cervical and lumbar spines, simply stated:

> I would therefore utilize the latitude afforded by the Almarez II decisions and revise his cervical spine and lumbar spine impairment ratings to zero percent whole person based on the range of motion and comfort as visualized in the video surveillance footage. I would also amend the pain add-on impairment to zero percent whole person impairment.

(Defendant's Exhibit S at p. 7.)

This opinion is conclusory at best, and does not comport to the specific parameters for a substantial opinion outlined in *Almarez II*. Dr. Chen makes no effort to specifically point out how a DRE II rating for either the cervical spine or the lumbar spine does not adequately encapsulate impairment. This is particularly troublesome here because, particularly for the cervical spine, there are diagnostic tests including multiple MRIs and electrodiagnostic studies that would meet the minimum findings for a DRE II rating. The AMA Guides at page 383 specifically note, "In category II, the individual has objective findings but no radiculopathy or alteration of structural integrity, while in category III, radiculopathy with objective verification must be present."

We note here that even in the original ratings, Dr. Chen does a poor job at the outset of correlating the specific objective findings with the DRE II ratings. Based on the record, it does not appear that the treatment reports after the August 9, 2023 QME report or updated MRIs for the cervical spine were sent to Dr. Chen for review in the November 2025 report. These cannot be disregarded and should have been interpreted by Dr. Chen and then compared to the functionality seen in the surveillance. The DRE categories are diagnosis based ratings, much like the rating for the distal clavicle resection is a diagnosis based rating. Just as Dr. Chen kept the rating for the shoulder intact, he should have discussed why a similar diagnosis based rating is undermined by the surveillance.

As the WCJ points out, Dr. Chen does not state how the surveillance is inconsistent with the strict rating. He does not point to another chapter, chart, or page number within the "four corners" of the AMA Guides to support the alternative rating of 0%. Defendant implies that Dr. Chen is using a Range of Motion method (ROM), however, he does not say he used ROM, nor has he applied the testing or analysis required for use of that chapter per section 15.8 of the AMA Guides. Ultimately, the *Almarez II* analysis fails.

Dr. Chen's opinion on the MMI date being, "at or before" the March 6, 2021 surveillance video is likewise unsupported. In addition to the language itself being speculative, the medical evidence does not support this finding. "'Permanent and stationary status' is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment." (Cal. Code Regs., tit. 8, § 9785 (a)(8); see also Cal. Code Regs., tit. 8, § 9811(k).) In this matter, applicant had surgery shortly after the March 2021 surveillance. Thus, by definition, applicant could not have been at MMI prior to June of 2021. Dr. Chen evaluated him in November of 2022, prior to the additional dates of surveillance, and also felt that applicant would benefit from further physical therapy. While Dr. Chen may believe that the cervical and lumbar spines were MMI prior to the March surveillance, it is clear that the right shoulder was not. Throughout 2024 and into 2025, there were additional MRIs, multiple surgical consultations, with recommendations for surgery, additional attempts at conservative care, and the denial of a functional restoration program. Though it seems that Dr. Lo was sent the surveillance, there is no comment in any of the reporting. Thus, the record is incomplete as to the point at which applicant was MMI.

We also disagree with Dr. Chen's opinion that all treatment rendered after the March 6, 2021 surveillance is nonindustrial, and that there is no need for future medical care for the neck and back. We emphasize the point made by the WCJ that this opinion amounts to impermissible apportionment of medical treatment. If the need for medical treatment is partially caused by an applicant's industrial injury, an employer must pay all the injured worker's reasonable medical expenses. (*Granado v. Workers' Comp. Appeals Bd.* (1968) 69 Cal.2d 399, [33 Cal.Comp.Cases 647].) An injured worker is entitled to medical care for a non-industrial condition that must be treated in order to cure or relieve the effects of an industrial injury. (*Bolton, supra*, 34 Cal.3d 159.)

Dr. Chen does not indicate any medical basis for cutting off industrial liability for medical treatment that he opined was warranted up to the point of the March 2021 surveillance. Likewise, his opinion still states that the injuries are 100% industrial. He is consistent that the industrial motor vehicle accident caused injury to the cervical and lumbar spines. There is no evidence anywhere in the record of an intervening event that would sever causation for ongoing care. Moreover, the spine is listed in diagnoses from the beginning of the medical record. Again, the opinion is not supported, is contradictory, and is not substantial.

Additionally, defendant notes in their supplemental Petition that there was an agreement that the March 6, 2021 surveillance could be sent to the QME despite a finding that the film was not authenticated and that it was not relevant to submit to the QME for review. First, there is nothing in the record to support an agreement between the parties that defendant would forego appeal of the decision in exchange for submission of the footage to the QME. Decisions of the Appeals Board "must be based on admitted evidence in the record." (*Hamilton v. Lockheed Corporation* (*Hamilton*) (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Board en banc).) Second, based on the record before us, the finding that the footage was not authenticated was not vacated or appealed and remains intact. To our knowledge, applicant never admitted that he was featured in the March 6, 2021 video and the record shows no indication that the QME asked him about the surveillance or that the QME was advised that there was a dispute as to identity. Thus, any opinion based on review of that footage would not be substantial medical evidence.

The record is then left with only the original reporting from the QME. We agree with defendant that the reporting is now stale and may not be based on a complete history. Further, the QME in his later opinions essentially rescinded his prior opinions at to MMI, permanent disability, and the need for future medical care.

The WCAB has a duty to further develop the record when there is a complete absence of (*Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389, 393-395 [62 Cal.Comp.Cases 924]) or even insufficient (*McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117, 1121-1122 [63 Cal.Comp.Cases 261]) evidence on an issue. In our en banc decision in *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2002) 67 Cal.Comp.Cases 138 (Appeals Board en banc), we stated that "[s]ections 5701 and 5906 authorize the WCJ and the Board to obtain additional evidence, including medical evidence, at any time during the proceedings (citations) [but] [b]efore directing augmentation of the medical record . . . the WCJ or the Board must establish as a threshold matter that specific medical opinions are deficient, for example, that they are inaccurate, *inconsistent or incomplete*." (*Id.* at p. 141, *italics added*.) Per *McDuffie*, if the existing physicians cannot cure the need for development of the record, the selection of an agreed medical evaluator (AME) should be considered by the parties. If the parties cannot agree to an AME, the WCJ can then appoint a physician to evaluate applicant's injury pursuant to section 5701. (*Ibid.*)

We are concerned that the QME's reporting cannot be rectified at this point. The QME admitted, in discussing the cumulative injury, that he had no interest in evaluating applicant as he had reviewed all the records and seen him multiple times. Upon return, the WCJ must consider whether proceeding with a new evaluator would be the best course.

Accordingly, we grant the Petition for Reconsideration, rescind the F&A and return the matter to the trial level for further proceedings consistent with this decision.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration of the decision of April 24, 2026 is **GRANTED**.

IT IS FURTHER ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings, Award & Orders of April 24, 2026 is **RESCINDED** and that the matter is **RETURNED** to the WCJ for further proceedings consistent with this decision.

WORKERS' COMPENSATION APPEALS BOARD

/s/ PAUL F. KELLY, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

/s/ CRAIG L. SNELLINGS, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JULY 27, 2026

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

PING HUNG LI
GEORGE SURMAITIS
PURINTON LAW

TF/md

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