

**WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA**

ALEJANDRO CABRERA, *Applicant*

vs.

SUBSEQUENT INJURIES BENEFITS TRUST FUND, *Defendant*

**Adjudication Numbers: ADJ14744840, ADJ12837154
San Francisco District Office**

OPINION AND DECISION AFTER RECONSIDERATION

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

Applicant seeks reconsideration of the Joint Findings and Order (F&O) issued on November 23, 2022, wherein the workers' compensation administrative law judge (WCJ) found that (1) in ADJ1287154, while employed during the period through June 13, 2019, applicant sustained injury arising out of and in the course of employment to his heart, psyche, neck and bilateral upper extremities; (2) in ADJ14744840, while employed during the period through October 7, 2013, applicant did not sustain injury arising out of and occurring in the course of employment to his heart/cardiovascular system; (3) in ADJ1287154, applicant sustained permanent atrial disability, after adjustment for age, occupation and apportionment, of 17%; and (4) applicant did not meet his burden of proof of entitlement to benefits from the Subsequent Injuries Benefits Trust Fund (SIBTF).

The WCJ ordered that applicant take nothing on his claim for SIBTF benefits.

Applicant contends that the WCJ erroneously failed to (1) find that he had preexisting permanent disability in the form of hypertension; (2) find that his preexisting permanent disability and subsequent disability met the 70% threshold under Labor Code section 4751; (3) find that his subsequent injury included injury to the psyche and in the form of cardiomyopathy; (4) rate the permanent disability resulting from subsequent injury in the form of carpal tunnel syndrome; (4) find that applicant sustained permanent disability on October 7, 2013; and (5) find that applicant is 100% permanently disabled.

We did not receive an Answer from defendant.

We received a Report and Recommendation on Petition for Reconsideration (Report) from the WCJ recommending that the Petition be denied.

We have reviewed the contents of the Petition and the Report. Based upon our review of the record, and for the reasons discussed below, as our Decision After Reconsideration, we will rescind the F&O and substitute findings that (1) applicant had preexisting permanent disability resulting from obstructive sleep apnea of 7%; (2) the issue of whether applicant had preexisting permanent disability resulting from coronary heart disease is deferred; (3) the issue of whether applicant had subsequent permanent disability equal to 35% or more of his total disability pursuant is deferred; and (4) the issues of whether applicant's combined preexisting and subsequent permanent disability equals 70% or more, and, as appropriate, the amount of applicant's total disability, are deferred; and we will return the matter to the trial level for further proceedings consistent with this decision.

FACTUAL BACKGROUND

On June 17, 2021, a WCJ approved a compromise and release between applicant and defendant Stanford Health Care on applicant's claim in ADJ12837154 of cumulative injury to the upper extremities, neck, psyche, and circulatory system during the period ending June 13, 2019, and awarded applicant the sum of \$200,000.00. (Order Approving Compromise and Release, June 17, 2021.)

On July 9, 2021, a WCJ approved a compromise and release between applicant and defendant Stanford Health Care on applicant's claim in ADJ1474484 of cumulative injury to the circulatory system during the period of October 7, 2012 through October 7, 2013, and awarded applicant the sum of \$100,000.00. (Order Approving Compromise and Release, June 17, 2021.)

On August 16, 2021, applicant filed a petition for SIBTF benefits in ADJ12837154, alleging that he sustained cumulative injury to the upper extremities, neck, psyche, and circulatory system during the period ending on June 13, 2019, with resulting permanent disability, when considered alone and without regard to or adjustment for his occupation or age equal to 100% percent or more of total disability. (Petition for SIBTF Benefits, August 16, 2021, p. 1.) Applicant further alleged that he experienced heart failure in 2013

and 2014 which resulted in permanent disability prior to the alleged cumulative injury for which he filed a workers' compensation claim in ADJ14744840. (*Id.*, p. 2.)

On September 21, 2022, the WCJ ordered that ADJ12837154 and ADJ14744840 be consolidated and the matters proceeded to trial of the following issues:

In ADJ12837154:

1. Permanent disability.
2. Entitlement to Subsequent Injuries Benefits Trust Fund benefits, with the applicant claiming he is 100 percent permanently and totally disabled.
3. Attorneys' fees.

In ADJ14744840:

1. Injury arising out of and in the course of employment.
2. Permanent disability.
3. Entitlement to SIBTF benefits.
4. Attorneys' fees.

(Minutes of Hearing, Order of Consolidation, and Summary of Evidence, September 21, 2022, p. 3:1-40.)

The parties stipulated that applicant sustained injury arising out of and in the course of employment to the heart, psyche, neck, and bilateral upper extremities while employed during the period through June 13, 2019 (ADJ12837154) and claims to have sustained injury arising out of and in the course of employment to his heart/cardiovascular system while employed during the period through October 7, 2013 (ADJ14744840) (*Id.*, p. 2:6-33.)

The WCJ admitted into evidence an exhibit entitled Report of Scott Anderson, M.D., dated November 16, 2021. (*Id.*, p. 4:29.) In the Report, Dr. Anderson states that applicant had preexisting permanent disability described as follows:

Obstructive sleep apnea -Table 13-4 for sleep disorder, he does not appear particularly somnolent. His Epworth sleepiness scale is slightly elevated and I would rate him at 5% Whole Person Impaired.

The above-described whole person impairments would need to be adjusted to reflect the age and occupation.

(Ex. 106, Report of Scott Anderson, M.D., dated November 16, 2021, p. 44.)

Dr. Anderson further states:

At this point, I wish to respond to some questions relative to the SIBTF process:

...

Is the total disability equal to or greater than 70% after modification?

Yes, the total disability is equal or greater than 70% after modification.

(*Id.*, pp. 47-48.)

The WCJ admitted into evidence an exhibit entitled Report of Vladimir Bokarius, M.D., dated September 29, 2020. (Minutes of Hearing, Order of Consolidation, and Summary of Evidence, September 21, 2022, p. 4:24.) In the Report, Dr. Bokarius opines as follows:

DIAGNOSES:

296.21 (F32.0) Major Depressive Disorder, Single Episode, Mild, In Anxious Distress

V62.29 (Z56.9) Other Problem Related to Employment

Chronic Neuropathic Pain; Obstructive Sleep Apnea; Hypertension; Coronary Artery Disease

...

CAUSATION:

I find that the examinee's psychiatric injury meets the 51% predominant cause threshold for occurring in the course of and being the consequence of events of employment. Mr. Cabrera has no psychiatric history predating employ at Stanford, and there is no evidence in either his report or medical records that stressors outside the workplace contributed to symptom onset or progression. Although there is one reference to his father's passing and finances and another to concerns about loss of insurance benefits, these mentions are counterweighed by the abundance of references to work stress throughout that same year. (07/03/2019 R Witteles, MD; 08/14/2019 N Downing, MD). As such, by both examinee's present report and the available evidence, it appears that work events are the predominant causal vector.

...

ASSESSMENT OF DISABILITY:

...

Rating of permanent disability is not applicable at this time.

(Ex 102, Report of Vladimir Bokarius, M.D., dated September 29, 2020, pp. 17-19.)

In the Opinion on Decision, the WCJ states:

Ronald Chaplin evaluated the applicant as an orthopedic panel selected Qualified Medical Examiner (QME) on October 21, 2020. The applicant was complaining of pain in his bilateral hands and wrists which radiated to his arms and neck. Under the history of the injury, Dr. Chaplin noted that the applicant performed data entry 8 to 14 hours a day for the past 20 years. He diagnosed the applicant with cervicgia in the past and bilateral carpal tunnel syndrome. He opined that it was within a reasonable degree of medical probability that the applicant had repetitive overuse of the upper extremities which led to the development of bilateral carpal tunnel syndrome. He opined that the cervical issues were not work related. He did not believe the carpal tunnel was permanent and stationary, and no impairment ratings were given. (Joint Exhibit 101, Report of Ronald Chaplan, M.D. dated October 26, 2020, pages 2, 6, and 7.)

Vladimir Bokarius evaluated the applicant as a psychiatric panel QME on September 20, 2020. In his history, he noted that the applicant worked for Stanford Health Care as a Clinical Reviewer from April 1983 through June 2020. In 2009, he was charged with handling all bariatric surgeries which doubled his workload and he worked more than 8 hours a day. In 2010 he was made an hourly employee, took a pay cut in salary, and lost over 2000 hours of accumulated paid time off. By 2012 the work regarding bariatric surgeries was distributed equally among his team. He developed heart problems and underwent cardiac surgery in 2013 and denied any further psychiatric symptomatology until 2018. In 2018 he was put in charge of pain clinic patients and supervised a new team of reviewers. He was allowed to work overtime and would work late to help patients, but in the second part of 2019, overtime became very strict. He was placed on administrative leave without pay for working overtime and his employment was terminated in September, 2020. Dr. Bokarius noted that psychiatric symptoms first manifested around 2008 when he was assigned bariatric surgeries, improved by 2012 when he was no longer the only one to handle bariatric cases, and then returned in 2018. He diagnosed the applicant with a major depressive disorder which he found was predominantly caused by the applicant's employment at Stanford Health Care. However, he did not believe the condition was at maximum medical improvement. (Joint Exhibit 102, Report of Vladimir Bokarius, M.D., dated September 29, 2020, 2, 3, 5, 13, and 15.)

Applicant was evaluated by James Schmitz as an internal medicine/cardiovascular disease panel QME on September 17, 2020. The applicant was complaining of hypertension, coronary artery disease, idiopathic cardiomyopathy and peripheral edema. Dr. Schmitz noted that he was diagnosed with high blood pressure in approximately 1999, and was started on medication on August 27, 2001 but then stopped the medication on his own. On January 10, 2003, he was seen in follow-up following a minor motor vehicle accident with elevated blood pressure and medication

was resumed, before he again stopped taking it. On August 26, 2013 he was seen at Stanford Health Care with a two-week history of progressive symptoms of dyspnea and fatigue. An electrocardiogram taken in the emergency room was consistent with left ventricular hypertrophy, and he was admitted to hospital where a subsequent echocardiogram demonstrated an ejection fraction of 14% with global hypokinesis and left ventricular hypertrophy. He was discharged on August 29, 2013 with a diagnosis of heart failure of undetermined etiology. In terms of the coronary artery disease, he had a CT angiography performed on September 24, 2013 and was placed on medication. A coronary angiography was performed on October 7, 2013 after which he had a stent placed. A repeat echocardiographic three months later showed a markedly improved ejection fraction. On February 13, 2020, he presented for follow-up with complaints of progressive dyspnea and chest pain with exertion of the previous year. He appears to have declined a recommended coronary angiogram. He had been participating in cardiac rehabilitation for the three months prior to the evaluation. He also complained of obstructive sleep apnea for which he underwent a polysomnography study on September 19, 2013 and was diagnosed with severe obstructive sleep apnea and started on a continuous positive airway pressure ventilation (CPAP). (Joint Exhibit 103, Report of James Schmitz, dated September 17, 2020, pages 3, 4 and 5.)

Dr. Schmitz stated that the applicant hired by Stanford University Medical Center in 1993 into the medical record review section as a clinical reviewer. Between 1993 and 2000 he worked approximately twice the workload of his colleagues. Between 2006 and 2010 he was working between 12 to 14 hours a day five days a week and when he left Stanford he had over 2000 hours of PTO. His last day of work was on June 12, 2019. He was terminated for consistently working past the time he was supposed to be clocked out. Dr. Schmitz diagnosed the applicant with hypertension, idiopathic cardiomyopathy, coronary artery disease, and peripheral edema due to an anti-hypertensive drug, obstructive sleep apnea, erectile dysfunction and emotional stress/depression/anxiety, which was deferred to a QME in psychiatry. He opined that the hypertension was caused and/or aggravated by the long work hours of his job. Both the idiopathic cardiomyopathy and coronary artery disease were aggravated by the industrial hypertension. He found the obstructive sleep apnea to be nonindustrial, but did recommend treatment on an industrial basis to treat the hypertension and heart conditions. He opined that the erectile dysfunction was aggravated by the anti-hypertensive medication. (Joint Exhibit 103, Report of James Schmitz, dated September 17, 2020, pages 5, 14 and 15.)

Dr. Schmitz stated that both the hypertension and cardiomyopathy were at maximum medical improvement as of the date of the September 17, 2020 evaluation. The coronary artery disease was at maximum medical

improvement as of January 7, 2014, three months following the heart catheterization. Using Tables 4-1 and 4-2 of the AMA Guides, he found that the applicant had a 25% whole person impairment (WPI) for the hypertension. In terms of apportionment, he stated that the applicant had 6 known conditions that can contribute to hypertension including his sex, age, obesity, family history of hypertension, obstructive sleep apnea and long work hours, and opined that 17% of the impairment was due to a cumulative trauma while working for Stanford Health Care, with the rest due to nonindustrial factors. For the cardiomyopathy, he stated that the applicant was temporarily disabled between August 27, 2013 and February 12, 2014[4]. Using Table 3-9, he assigned 40% WPI. He noted that hypertension aggravated the cardiomyopathy, but found that all of the impairment was due to nonindustrial factors. For the coronary artery disease, he stated that the applicant was TTD from October 7, 2013 to January 7, 2014. Using Table 3-6a of the AMA Guides, he assigned 33% WPI. In terms of apportionment, he found that 20% of the coronary artery disease was due to the hypertension, which the remaining 80% was due to nonindustrial factors. (Joint Exhibit 103, Report of James Schmitz, dated September 17, 2020, pages 15, 17-19, 22-16.)

Dr. Schmitz prepared a supplemental report dated November 6, 2020. He reiterated that the applicant's cardiomyopathy was idiopathic in nature and aggravated by the industrial hypertension.

...

Dr. Schmitz was deposed on February 12, 2021. He testified that the applicant's hypertension and cardiomyopathy both reached maximum medical improvement on September 17, 2020. He found industrial causation for coronary artery disease which reached maximum medical improvement on January 7, 2014. He testified that the applicant's hypertension began a long time ago and continued throughout the course of his employment, and as a consequence of the hypertension he had both cardiomyopathy and coronary artery diseases. . . . He also couldn't testify what impairment, if any, he had at the time the applicant was discharged from the hospital in 2013. . .

Scott Anderson performed an evaluation for a claim against the Subsequent Injuries Benefits Trust Fund (SIBTF) on November 16, 2021. In his history, he noted that the applicant was employed as a clinical reviewer at Stanford Health Care from April 1993 until September, 2020 when he was terminated for working overtime hours after being told not to on multiple occasions. His chief complaint was heart failure. He developed symptomatic congestive heart failure 5 to 10 years ago and at one point he had an ejection fraction of 14% which gradually increased to 63% by 2019 which is suggestive of post viral cardiomyopathy. He has essential hypertension which has been present since 1993 and had been treated with medication. Complications include possible cardiomyopathy. He has

hypercholesterolemia which has been present for greater than 20 years and has been treated with medication. He has arteriosclerotic coronary artery disease and a history of prior myocardial infarction. He has sleep apnea which had been treated with an intermittent use of the CPAP device. He has been diagnosed with carpal tunnel syndrome based on EMG/nerve conduction studies which has not been treated surgically. His past surgical history included placement of the coronary stent in 2014 and a cardiac biopsy in 2014. (Joint Exhibit 106, Report of Scott Anderson, M.D., dated November 16, 2021, pages 3, 4 and 5.)

Dr. Anderson diagnosed the applicant with congestive heart failure due to hypertensive cardiomyopathy, essential hypertension hypercholesterolemia, arteriosclerotic coronary artery disease, status post myocardial infarction and stent placement, obstructive sleep apnea, and bilateral carpal tunnel syndrome. All conditions are permanent and stationary. He opined that there was a component of industrial causation for the congestive heart failure, hypertension, arteriosclerotic coronary artery disease, and bilateral carpal tunnel syndrome. He also opined that the hypercholesterolemia and obstructive sleep apnea were pre-existing and non-industrial. He stated there is documentation that the medical records of the hypertension was related in part to stress of the job. There was no documentation suggesting viral etiology of the cardiomyopathy so it was most likely caused by the industrial hypertension. He also opined that the heart disease was related to the stress at work. He opined that the carpal tunnel was caused by repetitive typing industrially. In terms of impairment, using Table 3-9 of the AMA Guides he assigned 40% WPI for the congestive heart failure. Using Table 4-2 of the AMA Guides he assigned 16% WPI for the hypertension. Using Table 3-6A of the AMA Guides he assigned 38% WPI for the arteriosclerotic coronary artery disease, and 9% whole person impairment for each upper extremity for the carpal tunnel using Tables 16-10 and 16-11. 43. There was no rating for the high cholesterol. He assigned a 5% whole person impairment of the obstructive sleep apnea using Table 13-4. In terms of apportionment, the he stated that for the congestive heart failure, hypertension and coronary artery disease, 60% or the impairment was industrial and 40% idiopathic. There was no further explanation as to how he arrived at those percentages. There was no apportionment for the bilateral carpal tunnel. He stated that the nonindustrial component of apportionment or the nonindustrial cause condition manifested prior to the end of cumulative trauma and development of the subsequent disability, but no specific date was given as to when they became labor disabling. (Joint Exhibit 106, Report of Scott Anderson, M.D., dated November 16, 2021, pages 40, 41, 42, 43, 44, 45.)

...

The only report in evidence that addressed injury to the psyche with that of Dr. Bokarius, who stated that the applicant's psychiatric injury was not yet permanent and stationary. (Joint Exhibit 102, page 15.)

...
The panel selected QME orthopedic QME, Dr. Chaplin, did not provide any permanent disability to the upper extremities for the bilateral carpal tunnel syndrome. The only report in evidence from Dr. Chaplin states that the bilateral carpal tunnel was not yet permanent and stationary. (Joint Exhibit 101, page 7.)

...
Dr. Anderson, in his November 16, 2021 report, provided a different assessment of the level of permanent disability for the applicant's hypertension, and coronary artery disease than that of the panel selected QME, Dr. Schmitz. (Joint Exhibit 106, pages 42 -43.) In addition, he provided a different apportionment analysis for those the hypertension, cardiomyopathy and coronary artery disease. However, even though he reviewed the reporting of Dr. Schmitz, Dr. Anderson does not provide any explanation as to why he provides a different level permanent disability than that of the QME. Nor does he address why his findings regarding apportionment to nonindustrial factors differ substantially from the opinions of the panel selected QME. In terms of his apportionment analysis, for each of the three cardiac diagnoses (congestive heart failure, hypertension, and coronary artery disease) he provides the same percentage for apportionment between industrial and nonindustrial factors. (Id. at 44.) His opinions regarding apportionment are conclusory, with no explanation for how he arrived at his apportionment findings.

Dr. Anderson also incorrectly applies the AMA Guides for his assessment of the permanent disability for the bilateral upper extremities. For each upper extremity, he assigned a sensory deficit of 30% and a motor deficit of 20%. (Joint Exhibit 106 page 43.) Using table 16-15 of the AMA Guides, this would be a 12% for the median nerve deficit for sensory (not the 13% given by Dr. Anderson) as well as the 2% motor deficit which would be 14% upper extremity impairment. This translates to 8% WPI, not the 9% assigned by Dr. Anderson. I therefore do not find Dr. Anderson's opinions to be substantial medical evidence.

Dr. Schmitz, the panel selected QME, provided a 25% WPI for the hypertension, a 40% WPI for the cardiomyopathy, and a 33% WPI for coronary artery disease. (Joint Exhibit 103, pages 18-21.) He gave an extensive explanation for how he arrived at his opinions regarding apportionment for each of the three diagnoses. (Id. at pages 22 -26.) These were not challenged by either party in either the supplemental reporting for the deposition of Dr. Schmitz. I find the opinions of Dr. Schmitz to be substantial medical evidence.

I find that the permanent disability as a result of the cumulative trauma through June 13, 2019 to be as follows:

Hypertension: .17(04.01.00 – 25 – [1.4]35 – 111F – 35 – 44) 7%
Cardiomyopathy: 0(03.04.00.00 – 40% [1.4]56 – 111F – 56 – 66) 0%
Coronary artery disease: .2(03.02.00 – 33 – [1.4]46 – 111F – 46 – 56) 11%

Combined values chart: 17%

...

Dr. Schmitz notes that the applicant received treatment for hypertension and was taking medication for hypertension off and on over the years prior to his hospitalization in 2013. (Joint Exhibit 103, page 3.)

...

There is evidence that there is pre-existing disability as result of obstructive sleep apnea. Dr. Schmitz noted that the applicant underwent a polysomnography study in 2013, and was diagnosed with obstructive sleep apnea. (Joint Exhibit 103, page 5.) He found the obstructive sleep apnea to be nonindustrial, and did not address impairment. However, Dr. Anderson did address impairment for the obstructive sleep apnea using the AMA Guides, and assigned a 5% whole person impairment. (Joint Exhibit 106, page 43.)

The nonindustrial sleep apnea rates as follows

13.03 – 5% - [1.4] 7% - 111H – 7%

(Opinion on Decision, pp. 2-15.)

DISCUSSION

Labor Code section 4751¹ provides:

If an employee who is permanently partially disabled receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70 percent or more of total, he shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury compensation for the remainder of the combined permanent disability existing after the last injury as provided in this article; provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg, or an eye, and the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such latter permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to 5 percent or more of total, or (b) the permanent disability resulting from the subsequent injury, when

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

considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35 percent or more of total.

(§ 4751.)

In *Todd v. Subsequent Injuries Benefits Trust Fund* (2020) 85 Cal.Comp.Cases 576, 581-582 [2020 Cal. Wrk. Comp. LEXIS 35] (Appeals Board en banc), we stated that an employee must prove the following elements to recover subsequent injuries fund benefits:

(1) a preexisting permanent partial disability;

(2) a subsequent compensable injury resulting in additional permanent partial disability:

(a) if the previous permanent partial disability affected a hand, an arm, a foot, a leg, or an eye, the subsequent permanent disability must affect the opposite and corresponding member, and this subsequent permanent disability must equal to 5% or more of the total disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee; or

(b) the subsequent permanent disability must equal to 35% or more of the total disability, when considered alone and without regard to, or adjustment for, the occupation or the age of the employee;

(3) the combined preexisting and subsequent permanent partial disability is greater than the subsequent permanent partial disability alone; and

(4) the combined preexisting and subsequent permanent partial disability is equal to 70% or more. ([Lab. Code] § 4751.)

(*Todd v. Subsequent Injuries Benefits Trust Fund* (2020) 85 Cal.Comp.Cases 576, 581-582 (Appeals Board en banc).)

In *Ferguson v. Industrial Acc. Com.* (1958) 50 Cal.2d 469 [23 Cal.Comp.Cases 108], the Supreme Court held that the "previous disability or impairment" contemplated by section 4751 "must be actually 'labor disabling,' and that such disablement, rather than 'employer knowledge,' is the pertinent factor to be considered in determining whether the employee is entitled to subsequent injuries payments under the terms of section 4751." (*Ferguson, supra*, at p. 477.) The Court further noted that "the prior injury under most statutes should be one which, if industrial, would be independently capable of supporting an award. It need not, of course, be reflected in actual disability in the form of loss of

earnings [as this court has already held in *Smith v. Industrial Acc. Com.* (1955) 44 Cal.2d 364, 367 [288 P.2d 64]], but if it is not, it should at least be of a kind which could ground an award of permanent partial disability...." (*Ferguson, supra*, (quoting Larson's Workmen's Compensation Law (1952) § 59.33, vol. 2, p. 63).)

Further, the preexisting disability "need not have interfered with the employee's ability to work at his employment in the particular field in which he was working at the time of the subsequent injury. [citations]" (*Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App3d 224, 238.) "The ability of the injured to carry on some type of gainful employment under work conditions congenial to the preexisting disability does not require a finding that the preexisting disability does not exist. [citations]" (*Id.*)

Preliminarily, we note that we are unable to discern support for the WCJ to have consolidated ADJ12837154 and ADJ14744840 and determined the issue of whether applicant sustained injury to his heart/cardiovascular system while employed by defendant during the period ending October 7, 2013 in ADJ14744840.

The petition for SIBTF benefits was filed in ADJ12837154. It alleges that applicant (1) sustained subsequent injury with resulting permanent disability to the upper extremities, neck, psyche, and circulatory system during the period ending on June 13, 2019; (2) had preexisting permanent disability for which he sought workers' compensation benefits in ADJ14744840; and (3) is entitled to SIBTF benefits. (Petition for SIBTF Benefits, August 16, 2021, pp. 1-2.)

However, the claim for workers' compensation benefits in ADJ14744840 was resolved by Order Approving Compromise and Release; and the pleadings record does not show that the claim was reopened or that any issue was pending therein. (Order Approving Compromise and Release, June 17, 2021.)

Given that the issue of whether applicant is entitled to SIBTF benefits was pending in ADJ12837154 and the issue of whether he sustained injury in ADJ14744840 was resolved, the WCJ should have framed the issues of permanent disability, entitlement to SIBTF benefits, and attorney fees solely for trial solely in ADJ12837154 and refrained from determining any issue in ADJ14744840.

Accordingly, we will rescind the F&O.

Turning to ADJ12837154, we observe that the first element of proof of entitlement to SIBTF benefits may be established by substantial medical evidence of preexisting permanent disability, regardless of whether the disability was industrial or nonindustrial in origin or developed from a congenital, developmental, pathological, or traumatic source. (*Todd, supra; Franklin, supra*, at p. 238; see *Escobedo v. Marshalls, CNA Ins. Co.*, (2005) 70 Cal.Comp.Cases 604, 619 (citing *Subsequent Injuries Fund v. Workmen's Comp. Appeals Bd. (Talcott)* (1970) 2 Cal.3d 56, 62 [35 Cal.Comp.Cases 80].)

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, supra.*) "Medical opinion ... 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, 97].)

Pursuant to Table 13-4 of the AMA Guides, sleep impairments are classified based on daily functioning and objective testing including the Epworth Sleepiness Scale. In particular, Class 1 sleep impairments are shown by reduced daytime alertness and a sleep pattern where the individual can perform most activities of daily living and are ratable between 1% and 9%.

Here, the record shows that (1) Dr. Schmitz diagnosed applicant in 2013 with obstructive sleep apnea; (2) Dr. Anderson rated the resulting permanent disability at 5% based upon the Epworth Sleepiness Scale; and (3) permanent disability resulting from obstructive sleep apnea was found to be 7% after adjustment for age and occupation. (Opinion on Decision, p. 13; Ex. 106, Report of Scott Anderson, M.D., dated November 16, 2021, p. 44.)

On this record, we concur with the WCJ that substantial medical evidence supports a finding that applicant had preexisting permanent disability resulting from obstructive sleep apnea.

Accordingly, we will substitute a finding that applicant had preexisting permanent disability resulting from obstructive sleep apnea of 7%.

We also recognize that Dr. Schmitz reported that applicant was diagnosed with coronary artery disease for which he underwent heart catheterization surgery and was

temporarily totally disabled from October 7, 2013 to January 7, 2014. (Opinion on Decision, p. 5.)

This suggests that applicant may also establish that he had preexisting permanent disability resulting from coronary artery disease. However, the medical record regarding whether he had such a preexisting permanent disability is unclear. Specifically, although Dr. Schmitz opined that applicant's subsequent injury in the form of hypertension resulted in permanent disability of 25%, he was unable to testify as to what impairment, if any, applicant had in 2014 after his heart stent placement surgery and temporary total disability. (Opinion on Decision, pp. 6-12.)

Section 5313 requires the WCJ to state the "reasons or grounds upon which the [court's] determination was made." (See also *Blackledge v. Bank of America* (2010) 75 Cal.Comp.Cases 613, 621–22 [2010 Cal. Wrk. Comp. LEXIS 74].) The WCJ's opinion on decision "enables the parties, and the Board if reconsideration is sought, to ascertain the basis for the decision, and makes the right of seeking reconsideration more meaningful." (*Hamilton v. Lockheed Corporation (Hamilton)* (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Board en banc), citing *Evans v. Workmen's Comp. Appeals Bd.* (1968) 68 Cal.2d 753, 755 [33 Cal.Comp.Cases 350, 351].) A decision must be based on admitted evidence in the record and must be supported by substantial evidence. (*Hamilton, supra*, at p. 478; §§ 5903, 5952.) The "WCJ is charged with the responsibility of referring to the evidence in the opinion on decision, and of clearly designating the evidence that forms the basis of the decision." (*Hamilton, supra*, at pp. 475.)

The Appeals Board has the discretionary authority to develop the record when the medical record is not substantial evidence or when appropriate to fully adjudicate the issues. (§§ 5701, 5906; *Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389 [62 Cal.Comp.Cases 924]; see *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117 [63 Cal.Comp.Cases 261].)

In our en banc decision in *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2001) 67 Cal.Comp.Cases 138 (Appeals Board en banc), we stated that "[s]ections 5701 and 5906 authorize the WCJ and the [Appeals] 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 [Appeals] Board

must establish as a threshold matter that specific medical opinions are deficient, for example, that they are inaccurate, inconsistent or incomplete." (*McDuffie, supra*, at p. 141.) The preferred procedure is to allow supplementation of the medical record by the physicians who have already reported in the case. (*Id.*)

Pursuant to these authorities, we are persuaded that the record should be developed as to the issue of whether applicant had preexisting permanent disability resulting from coronary heart disease.

Accordingly, we will substitute a finding that defers the issue of whether applicant had preexisting permanent disability resulting from coronary heart disease; and it is our non-binding recommendation that the parties seek further reporting from Dr. Schmitz on the issue.

As to the issue of whether applicant had subsequent permanent disability equal to 35% or more of the total disability, when considered alone and without regard to occupation or age, the parties stipulated that applicant sustained subsequent injury to the heart, psyche, neck, and bilateral upper extremities during the period ending June 13, 2019. (Minutes of Hearing, Order of Consolidation, and Summary of Evidence, September 21, 2022, p. 2:6-33.)

Section 5702 provides:

The parties to a controversy may stipulate the facts relative thereto in writing and file such stipulation with the appeals board. The appeals board may thereupon make its findings and award based upon such stipulation, or may set the matter down for hearing and take further testimony or make the further investigation necessary to enable it to determine the matter in controversy.
(§ 5702.)

Stipulations between counsel are a "substitute for proof" and binding on the parties "if within the authority of the attorneys," and on the court if "not contrary to law, court rule or policy." (*Greator v. Board of Administration* (1979) 91 Cal.App.3d 54, 58 [44 Cal.Comp.Cases 553].) Stipulations between counsel further "'the public policies of settling disputes and expediting trials...' (citation) 'and their use in workers' compensation cases should be encouraged.'" (*Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd. (Allen)* (2010) 181Cal.App.4th 752, 764 [75 Cal.Comp.Cases 1]; see *County of Sacramento*

v. Workers' Comp. Appeals Bd. (Weatherall) (2000) 77 Cal.App.4th 1114, 1121 [65 Cal.Comp.Cases 1].)

It is thus clear that the WCJ correctly found that applicant sustained injury arising out of and in the course of employment to the heart, psyche, neck, and bilateral upper extremities while employed during the period through June 13, 2019 in ADJ12837154.

The question before us, then, is whether the subsequent injury resulted in permanent disability of 35% or more of the total disability.

Here, the record shows that applicant sustained permanent disability from hypertension of 25% and permanent disability from coronary artery disease of 33% before adjustment for age and occupation. (Minutes of Hearing, Order of Consolidation, and Summary of Evidence, September 21, 2022, p. 2:6-11; Opinion on Decision, p. 13.)

Yet the WCJ found that applicant's combined subsequent permanent disability amounted to 17% after adjustment for occupation, age—and apportionment.

In *Bookout v. Workers' Comp. Appeals Bd.* (1976) 62 Cal.App.3d 214 [41 Cal.Comp.Cases 595], the Court of Appeal held that section 4751(b) excludes apportionment from the calculation of subsequent permanent disability because it “provides that the permanent disability resulting from the subsequent injury, *when considered alone*” must equal 35 percent or more of the total disability. (*Id.*, at p. 228 [Emphasis in original].)

It follows that the WCJ erroneously found that applicant sustained permanent atrial disability of 17% based upon apportionment. In consequence, the WCJ did not determine whether the permanent disability from hypertension of 25% and permanent disability from coronary artery disease of 33%, when considered alone and without adjustment for occupation or age, combined to meet the 35% threshold of section 4751(b).

Accordingly, we will substitute a finding that defers the issue of whether applicant had subsequent permanent disability equal to 35% or more of his total disability.

As to the issue of whether applicant's combined preexisting and subsequent permanent disability equal 70% or more, we have explained that the issue of preexisting disability remains undetermined because the record does not show the amount of permanent disability, if any, resulting from applicant's coronary artery disease and

temporary total disablement from October 7, 2013 to January 7, 2014. (Opinion on Decision, p. 5.)

In addition, although Dr. Anderson opined that applicant's total disability equals or exceeds 70%, we concur with the WCJ that his reporting on medical issues other than the rating of applicant's preexisting permanent disability resulting from obstructive sleep apnea fails to set forth reasoning to support its conclusions, and, therefore, is not substantial evidence. (Ex. 106, Report of Scott Anderson, M.D., dated November 16, 2021, p. 48; Opinion on Decision, p. 13.)

Moreover, although Drs. Bokarius and Chaplin respectively reported that applicant sustained subsequent injury to the psyche and in the form of carpal tunnel syndrome, there is no medical reporting regarding the amount of resulting permanent disability, if any. (Ex 102, Report of Vladimir Bokarius, M.D., dated September 29, 2020, pp. 17-19; Opinion on Decision, pp. 2, 12.)

We are therefore persuaded that the record requires further development on the issue of whether applicant's combined preexisting and subsequent permanent disability equals 70% or more.

Accordingly, we will substitute findings that defer the issues of whether applicant's combined preexisting and subsequent permanent subsequent permanent disability equals 70% or more; and, as appropriate, the amount of applicant's total disability. In doing so, it is our non-binding recommendation that the parties obtain further reporting from Drs. Bokarius and Chaplin as to the amount of permanent disability resulting from injury to the psyche and in the form of carpal tunnel syndrome.

Accordingly, as our Decision After Reconsideration, we will rescind the F&O and substitute findings that (1) applicant had preexisting permanent disability resulting from obstructive sleep apnea of 7%; (2) the issue of whether applicant had preexisting permanent disability resulting from coronary heart disease is deferred; (3) the issue of whether applicant had subsequent permanent disability equal to 35% or more of his total disability is deferred; and (4) the issues of whether applicant's combined preexisting and subsequent permanent disability equals 70% or more, and, as appropriate, the amount of applicant's total disability, are deferred; and we will return the 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 Joint Findings and Order issued on November 23, 2022 is **RESCINDED** and the following is **SUBSTITUTED** therefor:

FINDINGS OF FACT (ADJ1287154)

1. Applicant ALEJANDRO CABRERA born _____, while employed during the period through June 13, 2019 as a clinical review technician, Occupational Group Number 111, at Palo Alto, California, by Stanford Hospital, sustained injury arising out of and in the course of employment to his heart, psyche, neck and bilateral upper extremities.

2. Applicant had preexisting permanent disability resulting from obstructive sleep apnea of 7%.

3. The issue of whether applicant had preexisting permanent disability resulting from coronary heart disease is deferred.

4. The issue of whether applicant had subsequent permanent disability equal to 35% or more of his total disability is deferred.

5. The issues of whether applicant's combined preexisting and subsequent permanent disability equals 70% or more, and, as appropriate, the amount of applicant's total disability, are deferred.

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

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER



/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JUNE 4, 2026

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

**ALEJANDRO CABRERA
ARJUNA FARNWORTH, ESQ.
OFFICE OF THE DIRECTOR-LEGAL UNIT (OAKLAND)
LAUGHLIN, FALBO, LEVY & MORESI**

SRO/*kl*

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