WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

JEAN C. BESSETTE, ***Applicant***

vs.

SUBSEQUENT INJURIES BENEFITS TRUST FUND, ***Defendant***

Adjudication Number: ADJ10793343
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.[1]

Defendant Subsequent Injuries Benefits Trust Fund (SIBTF) seeks reconsideration of the Findings & Award (F&A) issued on July 12, 2022, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part that applicant, while employed as a custodian, sustained industrial injury to the cervical spine, thoracic spine, lumbar spine, knees, bilateral lower extremities, psyche, neurological system causing headaches, and in the form of an arousal disorder and sleep disturbance; that applicant was eligible for SIBTF benefits and entitled to 100% permanent disability; and that SIBTF was entitled to a credit for benefits received under the Order Approving Compromise & Release (OACR) but was not entitled to a credit against long-term disability benefits.

Defendant contends that the WCJ failed to make specific findings for the amounts of permanent partial disability that resulted from the subsequent injury alone and from the preexisting conditions. Defendant further contends that the WCJ erred in relying upon applicant's consultation reports to substantiate the preexisting disability to determine the permanent disability resulting from the subsequent industrial injury. Finally, defendant contends that applicant did not meet the 35% permanent disability threshold to merit entitlement to SIBTF benefits.

We have received an Answer from applicant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending we grant reconsideration only to find that

[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.

applicant's subsequent injury, when considered alone and without regard to for adjustment for age or occupation is 37% permanent disability and to renumber the findings of fact.

We have considered the allegations in the Petition and the applicant's Answer and the contents of the WCJ's Report. Based on our review of the record and the reasons discussed below, as our Decision After Reconsideration, we will amend the WCJ's F&A to clarify Finding of Fact 1 to reflect that during the period from October 1, 2015 to October 1, 2016, applicant sustained industrial injury to his cervical spine, thoracic spine, lumbar spine, shoulders, knees, bilateral lower extremities, psyche and neurological system, but otherwise affirm the F&A.

BACKGROUND

Applicant, while employed as a custodian during the period October 1, 2015 to October 1, 2016, sustained industrial injury to his cervical spine, thoracic spine, lumbar spine, shoulders, knees, bilateral lower extremities, psyche and neurological system.[2]

On July 16, 2019, a workers' compensation arbitrator issued an OACR for $60,000.00 resolving, in addition to case numbers ADJ10793343 and ADJ10793345, various other cases-in-chief with the Alternative Dispute Resolution Program.

On March 15, 2022, the parties appeared for trial seeking adjudication of applicant's entitlement to SIBTF benefits.

The parties jointly submitted into evidence the Agreed Medical Evaluator (AME) report of David Sones, M.D., (Joint Ex. F) and the AME reports and deposition of Gary Brazina, M.D., (Joint Exs. I-K), as well as Panel Qualified Medical Evaluator (PQME) reports of Lawrence Richman, M.D., (Joint Exs. G-H). Applicant submitted into evidence the QME reports of Barry Gwartz, M.D., (App. Ex. 1), Stephane Johnson, M.D., (App. Ex. 2), and Steven Scribner, D.C., (App. Ex. 3-4.)

In his report dated April 17, 2018, AME Dr. Brazina, after evaluating applicant, diagnosed applicant with degenerative cervical and lumbar disease with bilateral chondromalacia patellae. (Joint Ex. J, pp. 20-21.) With respect to his cervical spine, he has 6% whole person impairment (WPI) based on DRE Category 2 under Table 15-5 on page 392 of the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), reflecting his non-verifiable radicular complaints. With respect to his lumbar spine, he has 12% WPI based on DRE Category 3 under Table 15-3 on

[2] We note that the F&A omitted in the Findings of Fact 1 the shoulders and impermissibly added arousal disorder and sleep disturbance despite the stipulations to the contrary. (F&A, p. 1, Minutes of Hearing, 03/15/2022, 2:5-8.)

page 284 of the AMA Guides, reflecting his verifiable radicular complains. With respect to his thoracic spine, he has no WPI based on DRE Category 1 under Table 15-4 on page 389 of the AMA Guides. Finally, with respect to his lower extremities, he has 2% WPI for each knee based on Table 17-31 on page 544 of the AMA Guides, reflecting his chondromalacia with crepitation with motion and normal x-rays and a history of trauma. (*Id.* at p. 22.) Added together, they result in 22% WPI. (*Ibid.*)

With respect to apportionment, 20% of the permanent disability for the cervical spine related to nonindustrial pre-existing injuries and degenerative arthritis with 80% related to the industrial injury and 30% of the permanent disability for the lumbar spine and lower extremities related to degenerative arthritis with 70% due to the industrial injury. (*Id.* at p. 23.)

In his deposition dated May 7, 2019, AME Dr. Brazina testified that adding the impairments for the spine with the lower extremities was more accurate than combining by Combined Values Chart (CVC) because "the knees are synergistic with the low back [and a] bad gait can make the back worse and the spine is taken in its entirety as additive." (Joint Ex. K, p. 18:3-10.) He also found 3% WPI jointly for both shoulders based solely on pain. (*Id.* at p. 19:13-15.)

In his report dated July 27, 2017, PQME Dr. Richman, after evaluating applicant, diagnosed industrially caused sleep disturbance with consequential headaches. (Joint Ex. G, p. 55.) PQME Dr. Richman also documented that, prior to 2016, applicant had significant pre-existing medical and neurological conditions, including severe craniocerebral trauma from an assault and a motorcycle accident in his early twenties that required a cranioplasty and resulted in lasting brain changes. (*Id.* at p. 57.) Records reflect a history of seizures, most recently in 1997, chronic headaches, cognitive impairment, attention deficit, insomnia, anxiety, depression, and documented workplace harassment in 2007. Brain imaging between 2008 and 2010 showed structural abnormalities, including left-sided encephalomalacia and loss of brain tissue, consistent with prior trauma. He also had tinnitus, cranial nerve deficits affecting eye movement, and longstanding sleep disturbance. He treated with Ritalin and ongoing psychiatric care for his cognitive disorder. (*Id.* at pp. 57-58.)

With respect to permanent disability for his headaches, applicant has 2% WPI under the AMA Guides due to pain with 80% of the permanent disability apportioned to industrial factors with 20% to nonindustrial factors. With respect to his sleep disturbance, applicant has 5% WPI based on Class 1 under Table 13-4 on page 317 of the AMA Guides, reflecting his prior history of

sleep disturbance with 80% of the permanent disability apportioned to industrial factors with 20% to nonindustrial factors. (*Id.* at p. 58.)

Based on the above discussion, this resulted in permanent disability strings as follows:

CERVICAL SPINE - DRE CATEGORY 2
080% (15.01.01.00 - 06 – 08 - 340G - 09 - 12%) 10%
LUMBAR SPINE - DRE CATEGORY 1
070% (15.03.01.00 - 12 - 17 - 340G - 19 - 24%) 17%
SHOULDERS – OTHER
100% (16.02.02.00 - 03 - 04 – 340F - 04 - 05%) 5%
LEFT KNEE - ARTHRITIS
070% (17.05.03.00 - 02 - 03 - 340G - 04 - 05%) 4%
RIGHT KNEE - ARTHRITIS
070% (17.05.03.00 - 02 - 03 - 340G - 04 - 05%) 4%
HEADACHES - CONSCIOUSNESS DISORDER
080% (13.01.00.00 - 02 - 03 - 340D - 02 - 03%) 2%
SLEEP AND AROUSAL DISORDERS
080% (13.03.00.00 - 05 - 07 - 340D - 05 - 06%) 5%

In his report dated August 28, 2020, QME Dr. Gwartz, after evaluating applicant, took a history that, in 1975, applicant sustained a severe head injury during a physical assault, resulting in a skull fracture and a two-and-a-half week coma at Rancho Los Amigos Hospital. About a year later, he underwent a craniotomy with a metal plate to repair the fracture. Within one to two years post-surgery, he experienced a generalized seizure and treated with Dilantin and Phenobarbital for four to five years, discontinuing medication around 1983 or 1984 after remaining seizure-free. Medical records noted a seizure approximately five to six years ago, prior to his industrial injury, with no evidence of subsequent anti-seizure medication. His seizure history aligned with posttraumatic epilepsy, which typically manifests within two years of injury. With respect to his epilepsy, he has 5% WPI based on Class 1 under Table 13-3 on page 312 of the AMA Guides, reflecting a paroxysmal disorder with predictable features but unpredictable episodes that do not restrict usual activities, though they may pose a risk to the individual or limit daily activities. (App. Ex. 1, pp. 4-5.)

Since 1975, following a physical assault that caused a skull fracture and required a craniotomy with a metal plate, applicant has experienced recurrent headaches. Subsequent head injuries, including a severe motorcycle accident that left him in a two-month coma and a slip-and-fall causing blunt head trauma, worsened these headaches. Medical records dating back to 2006 document that he experienced daily recurrent headaches that existed well before the industrial injury. With respect to his headaches, he has 8.5% WPI based on Class 1 under Table 13-2 on page 309 of

the AMA Guides, reflecting his brief repetitive or persistent alteration of state of consciousness and minimal limitation in performing activities of daily living (ADLs). (*Id.* at pp. 6-7.)

Beginning in the 1990s, applicant's recurrent headaches and joint pain from physically demanding work disrupted his sleep. By the end of his shifts, he regularly experienced neck, back, and shoulder pain, which, combined with his headaches, caused daytime sleepiness and required him to take breaks at work. His insomnia and related sleep disturbances existed prior to the industrial injury. With respect to his sleep disorder, he has 11% WPI based on Class 2 under Table 13-4 on page 317 of the AMA Guides, reflecting his reduced daytime alertness with ability to perform some ADLs. (*Id.* at pp. 7-8.)

Since the 1990s, applicant experienced bleeding hemorrhoids. A 2013 colonoscopy at Kaiser Permanente revealed internal and external hemorrhoids, and he underwent a hemorrhoidectomy in 2015, all occurring before his industrial injury. With respect to his hemorrhoids, he has 10% WPI based on Class 2 under Table 6-4 on page 128 of the AMA Guides, reflecting objective evidence of rectal disease with anatomic alteration and intermittent gastrointestinal symptoms, including hemorrhoidal bleeding. (*Id.* at p. 8.)

For several years, applicant experienced seasonal nasal stuffiness, usually from pollen, and his Kaiser Permanente records show he used nasal sprays intermittently before his industrial injury. During this time, physical labor sometimes triggered shortness of breath. In recent years, his allergies have improved, and he no longer uses nasal sprays. With respect to his seasonal allergies, he has 11% WPI based on Class 2 under Table 11-6 on page 260 of the AMA Guides, reflecting shortness of breath not occurring at rest, but produced by prolonged exertion during the periods of time when he is experiencing nasal obstruction. (*Id.* at pp. 8-9.)

Over the years, applicant experienced recurrent gastritis, usually from overeating or taking nonsteroidal anti-inflammatory drugs for joint pain. He manages his indigestion and heartburn by modifying his diet and avoiding these medications. With respect to his gastritis, he has 5% WPI based on Class 1 under Table 6-3 on page 121 of the AMA Guides, reflecting signs of upper digestive tract disease with continuous treatment not required. (*Id.* at p. 9.)

Since the 1990s, applicant has experienced intermittent erectile dysfunction, though he has occasionally achieved erections sufficient for sexual intercourse without medication. He underwent a vasectomy in 1992 and still occasionally achieves erections adequate for vaginal penetration. With respect to his erectile dysfunction, he has 5% WPI based on Class 1 under Table 7-5 on

page 156 of the AMA Guides, reflecting that sexual function is possible but accompanied by varying difficulty with erection, ejaculation, or sensation. (*Id.* at p. 11.)

In her report dated July 2, 2020, QME Dr. Johnson, after evaluating applicant, took a history that he experienced longstanding and escalating psychiatric and cognitive difficulties that significantly affected his social, occupational, and daily functioning. Medical records document depression, anxiety, mood disturbances, and personality changes, often worsened by workplace stressors and perceived harassment. He displayed attention deficits, impulsivity, distractibility, forgetfulness, and difficulty completing tasks, which clinicians linked to predominantly inattentive ADHD. Neuropsychiatric evaluation confirmed cognitive deficits, and he began stimulant therapy with Ritalin. These challenges occurred alongside recurrent headaches, seizure activity, and medication effects (e.g., gabapentin), which further disrupted his mood and sleep. He also experienced marital and interpersonal conflicts, prompting couples therapy and anger management interventions. Providers recommended stress management programs, and records show that his psychiatric, cognitive, and medical challenges required work accommodations, social work support, and ongoing monitoring, reflecting substantial functional impairment even before the industrial injury date. (App. Ex. 2, p. 5)

Prior to his industrial injury, applicant experienced lifelong depression, anxiety, and behavioral difficulties stemming from a traumatic childhood marked by frequent physical abuse from parents and stepparents, school bullying, and family instability. These experiences contributed to attention, focus, and impulse-control problems, leading to placement in continuation school and eventual high school dropout. After sustaining severe head injuries at ages 18 and 22, both resulting in extended comas, he developed significant cognitive impairments, including memory and speech difficulties, along with marked impulsivity and emotional dysregulation. During recovery, he struggled with substance use, social instability, and occupational limitations, requiring Social Security disability. Despite completing his General Educational Development and working in sheltered employment, these pre-existing psychiatric and cognitive impairments persisted, including ongoing depression, anxiety, memory deficits, and impaired executive functioning, forming a longstanding psychological disability prior to the industrial injury. (*Id.* at pp. 8-9.)

QME Dr. Johnson opined that applicant had a pre-existing Global Assessment of Functioning of 57 translating into 20% WPI. (*Id.* at p. 26.)

Based on the above discussion, this resulted in permanent disability strings as follows:

EPILEPSY – EPISODIC NEUROLOGIC DISORDER
13.02.00.00 - 5 - 7 - 340F - 7 - 9%
HEADACHES - CONSCIOUSNESS DISORDER
13.01.00.00 - 9 - 13 - 340D - 10 - 13%
SLEEP AND AROUSAL DISORDERS
13.03.00.00 - 11 - 15 - 340D - 12 - 15%
HEMORRHOIDS - COLON, RECTUM, AND ANUS
06.02.00.00 - 10 - 14 - 340F - 14 - 18%
SEASONAL ALLERGIES – NOSE/THROAT/RELATED STRUCTURES-RESPIRATION
11.03.01.00 - 11 - 15 - 340F - 15 - 19%
GASTRITIS - UPPER DIGESTIVE TRACT
06.01.00.00 - 5 - 7 - 340F - 7 - 9%
ERECTILE DYSFUNCTION - REPRODUCTIVE SYSTEM
07.05.00.00 - 5 - 7 - 340F - 7 - 9%
PSYCHIATRIC - MENTAL AND BEHAVIORAL
14.01.00.00 - 20 - 28 - 340D - 24 - 30%

In his report dated April 29, 2020, QME Dr. Schribner, after evaluating applicant, took a history where he sustained multiple injuries while working for the City of Los Angeles as a Senior Custodian II in the General Services Department, with October 2016 as his last date of employment. He experienced orthopedic, psychological, internal, and neurological injuries from continuous trauma during his duties, which included lifting heavy objects, prolonged standing, and repetitive physical movements. He received significant medical treatment, including care from B. Sam Tabibian, M.D., a physical medicine and rehabilitation specialist, and Kaiser Permanente, where applicant had been a member since 1984. His treatment included physical therapy and medications, and he was under the care of a city psychologist for job-related stress and anxiety. (App. Ex. 4, pp. 4-5.)

Applicant reported ongoing orthopedic and non-orthopedic complaints related to his industrial injuries, including chronic cervical, thoracic, and lumbar spine pain, as well as bilateral knee pain, psychological symptoms, headaches, and sleep disturbance. His neck pain radiates into both shoulders, worsens with prolonged sitting and movement, and interferes with daily activities. Sitting, standing, lifting, bending, stairs, coughing, and sneezing, aggravate his low back pain, rated 5-7/10, with intermittent radiation into his buttocks and legs. He also experiences daily mid-back pain that increases with bending, lifting, and twisting. His left knee pain, rated 5-8/10, is constant and associated with swelling, popping, numbness, weakness, and instability, while his right knee pain, rated 3–5/10, presents with similar but somewhat less severe symptoms. Both worsen with

standing, stairs, uneven surfaces, and squatting, and he uses a cane for ambulation. Additionally, he reported depression and anxiety related to his injuries, near-daily headaches with occasional aura and nausea, and worsening sleep difficulties, all of which interfere with his normal activities of daily living. (*Id.* at pp. 7-9.)

Applicant has a longstanding history of orthopedic and non-orthopedic conditions predating his subsequent industrial injuries. Orthopedically, he reports chronic neck pain stemming from a 2008 motor vehicle accident with whiplash, ongoing low back pain since 2010 with intermittent radiation into the legs, and bilateral knee pain since 2010 with swelling, weakness, and functional limitations requiring cane use. He also has residual right-hand tendon damage from a 1972 injury that resulted in permanent functional limitations. Non-orthopedic conditions include longstanding vision impairment, left eye paralysis, epilepsy, hearing loss with tinnitus, prior concussions, urological problems, obesity, hyperlipidemia, chronic headaches, depression and anxiety, insomnia, hemorrhoids, seasonal allergies, and gastrointestinal disorders. Collectively, these conditions have interfered with his ability to perform normal activities of daily living over many years. (*Id.* at pp. 9-13.)

In his supplemental report dated November 5, 2020, QME Dr. Schribner concluded that applicant met the 35% overall impairment, the 5% equal and opposing extremity, and the 70% combined subsequent injury and preexisting condition thresholds, thereby qualifying for SIBTF benefits. (App. Ex. 3, p. 2.) Applicant's medical records, spanning several decades, document longstanding psychiatric and orthopedic issues, including workplace conflicts, human resources concerns, neuropsychiatric and inpatient evaluations, and traumatic brain injury-related records. (*Id.* at p. 5.)

In addition, QME Dr. Schribner opined that applicant is effectively limited to sedentary work, able to perform tasks primarily while sitting with minimal physical effort, occasional standing or walking, and frequent breaks every 10 to 15 minutes to manage musculoskeletal conditions. Even in a sheltered workshop setting, he would struggle to compete in the open labor market. Combined with his psychiatric, orthopedic, and internal medical impairments, these restrictions render him 100% permanently disabled and unable to engage in competitive employment. (*Id.* at p. 12.)

QME Dr. Schribner opined that addition best reflects applicant's disability because his impairments interact and amplify each other, directly limiting his daily functioning. His orthopedic, internal medicine, and psychiatric conditions reduce his strength, endurance, adaptability, and social

engagement, making tasks like walking, lifting, sitting, and handling day-to-day challenges significantly harder. Unlike the CVC method, which focuses on overlapping body parts, simple addition captures how each impairment compounds the others, showing the full impact on his ability to perform work and daily activities. By accounting for these synergistic effects, simple addition accurately represents how his combined impairments hinder his independence and employability. (*Id.* at pp. 13-14.)

On July 12, 2022, the WCJ issued her F&A, finding applicant eligible for SIBTF benefits and entitled to 100% permanent disability, less benefits received under the OACR but not from long-term disability.

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

DISCUSSION

The SIBTF provides benefits to employees who establish that at the time of an industrial injury, they suffered from pre-existing 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. Ind. Acc. Com.* (*Patterson*) (1952) 39 Cal.2d 83, 86 [17 Cal.Comp.Cases 142]; *Ferguson v. Ind. Acc. Com.*, 50 Cal.2d 469, 475 [23 Cal.Comp.Cases 108]; *Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 619 (Appeals Board en banc).)

Labor Code section 4751[3] provides that if an employee with a pre-existing 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 pre-existing 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.)

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

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.)

In *Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686 (Appeals Board en banc) (*Vigil*), the Appeals Board held that an 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.)

For SIBTF claims, the workers' compensation medical discovery statutes (Lab. Code, §§ 4060–4068) do not apply because SIBTF claims involve issues that differ from prior workers' compensation evaluations. Due process requires that both the employee and SIBTF have a fair opportunity to obtain medical evidence specific to the claim. Accordingly, the employee may select QMEs to evaluate and report on the relevant issues, and SIBTF is responsible for paying the reasonable fees under the medical-legal fee schedule. The reports are admissible as evidence, and a WCJ will weigh them and issue a reasoned decision considering their substantiality. (*Duncan v.*

Workers' Comp. Appeals Bd. (*Moyers*) (2010) 75 Cal.Comp.Cases 762, 764-765 (writ denied); see *Conley v. Subsequent Injuries Benefits Trust Fund* (2025) 90 Cal.Comp.Cases 563, 573 ("[W]e are unaware of any authority for the proposition that a claim for SIBTF benefits is limited to the pleadings and evidence generated during litigation of the underlying claim where the underlying claim was settled without adjudicated findings").)[4]

Finally, 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); *Bookout v. Workers' Comp. Appeals Bd.* (1976) 62 Cal.App.3d 214, 228 [41 Cal.Comp.Cases 595].)

Here, we can discern no error in the WCJ's reliance on QME Dr. Gwartz, QME Dr. Johnson and QME Dr. Schribner in order to determine applicant's eligibility for SIBTF benefits pursuant to *Duncan*.

In addition, we do not find AME Dr. Brazina's deposition testimony finding 3% WPI for applicant's both shoulders based solely on pain to be persuasive given that, if we divided them equally between each shoulders and rounded it, they would result in 4% WPI. In addition, the pain add-on would overlap with PQME Dr. Richman's 2% WPI for headaches due to pain. However, QME Dr. Schribner endorses adding the orthopedic, internal medicine, and psychiatric conditions based on the described impacts on applicant's non-overlapping ADLs in accordance with *Vigil*. Accordingly, without taking into consideration apportionment and adjustments for occupation and age, we conclude that applicant's permanent cumulative injury disability for purposes of the 35% eligibility threshold is as follows:

ELIGIBILITY THRESHOLD

CERVICAL SPINE - DRE CATEGORY 2
15.01.01.00 - 06 – 08
LUMBAR SPINE - DRE CATEGORY 1
15.03.01.00 - 12 - 17
LEFT KNEE – ARTHRITIS
17.05.03.00 - 02 - 03
RIGHT KNEE - ARTHRITIS

[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.

17.05.03.00 - 02 - 03
HEADACHES - CONSCIOUSNESS DISORDER
13.01.00.00 - 02 - 03
SLEEP AND AROUSAL DISORDERS
13.03.00.00 - 05 – 07
8 + 17 + 3 + 3 + 3 + 7 = 41%, which meets the 35% eligibility threshold.

In our next step, we determine the "combined permanent disability" under section 4751, by adding the prior and subsequent permanent disabilities while excluding any overlapping impairments, less the amount due to the employee from the subsequent injury and less credits allowable under section 4753 to determine if they equal 70%. (*Todd*, *supra*, 85 Cal. Comp. Cases at p. 578.) Section 4751 does not qualify the 70% eligibility threshold, unlike the 35% eligibility threshold, by taking out adjustments for the occupation and age of the employee. (*Corrales v. Subsequent Injuries Benefits Trust Fund* [2025 Cal. Wrk. Comp. P.D. LEXIS 367, *13].) In addition, the extent of the employee's combined permanent disability at the time of the subsequent injury determines the measure of SIBTF's liability. (*Toma v. Basic Electric, Inc.* [2013 Cal. Wrk. Comp. P.D. LEXIS 583, *8], writ denied sub nom. *Toma v. Workers' Comp. Appeals Bd.* (2014) 79 Cal.Comp.Cases 617.)

Here, we calculate the overall permanent disability as follows:

SUBSEQUENT INJURY DISABILITY

CERVICAL SPINE - DRE CATEGORY 2
080% (15.01.01.00 - 06 – 08 - 340G - 09 - 12%) 10%
LUMBAR SPINE - DRE CATEGORY 1
070% (15.03.01.00 - 12 - 17 - 340G - 19 - 24%) 17%
SHOULDERS – OTHER
100% (16.02.02.00 - 03 - 04 – 340F - 04 - 05%) 5%
LEFT KNEE - ARTHRITIS
070% (17.05.03.00 - 02 - 03 - 340G - 04 - 05%) 4%
RIGHT KNEE - ARTHRITIS
070% (17.05.03.00 - 02 - 03 - 340G - 04 - 05%) 4%
HEADACHES - CONSCIOUSNESS DISORDER
080% (13.01.00.00 - 02 - 03 - 340D - 02 - 03%) 2%
SLEEP AND AROUSAL DISORDERS
080% (13.03.00.00 - 05 - 07 - 340D - 05 - 06%) 5%
COMBINE BY ADDITION (10+17+5+4+4+2+5) = 47 PD

PRE-EXISTING DISABILITY

EPILEPSY – EPISODIC NEUROLOGIC DISORDER
13.02.00.00 - 5 - 7 - 340F - 7 - 9%
HEADACHES - CONSCIOUSNESS DISORDER

13.01.00.00 - 9 - 13 - 340D - 10 - 13%
SLEEP AND AROUSAL DISORDERS
13.03.00.00 - 11 - 15 - 340D - 12 - 15%
HEMORRHOIDS - COLON, RECTUM, AND ANUS
06.02.00.00 - 10 - 14 - 340F - 14 - 18%
SEASONAL ALLERGIES – NOSE/THROAT/RELATED STRUCTURES-RESPIRATION
11.03.01.00 - 11 - 15 - 340F - 15 - 19%
GASTRITIS - UPPER DIGESTIVE TRACT
06.01.00.00 - 5 - 7 - 340F - 7 - 9%
ERECTILE DYSFUNCTION - REPRODUCTIVE SYSTEM
07.05.00.00 - 5 - 7 - 340F - 7 - 9%
PSYCHIATRIC - MENTAL AND BEHAVIORAL
14.01.00.00 - 20 - 28 - 340D - 24 - 30%

COMBINE BY CVC (9 C 13 C 15 C 18 C 19 C 9 C 9 C 30) = 74 PD
74% + 47% = 121 overall PD (over 70% PD for SIBTF eligibility)

Accordingly, given that the overall permanent disability award exceeds 100%, as our Decision After Reconsideration, we amend the WCJ's F&A to clarify Finding of Fact 1 to reflect the stipulated period of injurious exposure and body parts injured, but 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 August 11, 2022, is **AFFIRMED** except it is **AMENDED** as follows:

FINDINGS OF FACT

1. Jean C. Bessette, while employed as a custodian, occupational group number 340, during the period from October 1, 2015 to October 1, 2016, sustained industrial injury to his cervical spine, thoracic spine, lumbar spine, shoulders, knees, bilateral lower extremities, psyche and neurological system.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

/s/ ANNE SCHMITZ, DEPUTY COMMISSIONER

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.

JEAN C. BESSETTE
GLAUBER BERENSON VEGO, LLP
OFFICE OF THE DIRECTOR – LEGAL UNIT

DLP/md

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