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