WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

SILVIA FERNANDEZ, *Applicant*

vs.

SUBSEQUENT INJURIES BENEFITS TRUST FUND, *Defendant*

Adjudication Number: ADJ9928682
Oxnard District Office

OPINION AND DECISION AFTER RECONSIDERATION

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

Applicant seeks reconsideration of the Findings of Fact (Findings) issued on May 10, 2023 by the workers' compensation judge (WCJ). The WCJ found, in pertinent part, that applicant, who sustained a subsequent cumulative industrial injury to her neck, shoulders, and elbows during the period from June 10, 2014 to April 21, 2015, met the 5% threshold and had a preexisting labor-disabling condition, but was not entitled to Subsequent Injuries Benefits Trust Fund (SIBTF) benefits because she did not demonstrate her overall permanent disability was 70% or greater.

Applicant claims that she met the criteria for SIBTF eligibility, asserting that her overall permanent disability is 100% when combining her subsequent injury with her preexisting spinal, knee, and psychiatric conditions, and alternatively argues that development of the record is appropriate rather than an outright denial of benefits.

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

We have considered the allegations in the Petition, the Answer, and the contents of the WCJ's Report with respect thereto. Based on our review of the record and the reasons discussed below, as our Decision After Reconsideration, we rescind the Findings and return the matter to the trial level for further proceedings consistent with this decision.

BACKGROUND

Applicant, while employed during the period June 10, 2014 to April 21, 2015 as an assembler/quality control inspector for Waterway Plastics, Inc., sustained industrial injury to her neck, shoulders and elbows. (Minutes of Hearing (MOH), 02/22/2023, 2:4-7.)

The parties also entered into the following stipulations:

> 4. There was a Joint Compromise and Release for ADJ9928682, ADJ3992687, and ADJ284264 in 2017 based on the findings of the AME Dr. Fishman based on permanent disability of 28[%] for the neck, bilateral shoulders, and bilateral elbows for the Case No. ADJ9928682 injury.
>
> 5. Applicant has Prior Labor Disabling Disability at the time of the SII.

(MOH, 02/22/2023, 2:11-15.)

The parties requested adjudication of the compensability of applicant's claim of injury to her psyche and entitlement to SIBTF benefits. (MOH, 02/22/2023, 2:19, 22.)

Applicant submitted into evidence the Agreed Medical Evaluation (AME) reports of Bruce Fishman, M.D. (App. Exs. 4-6), as well as the QME reports of Dr. Ambrose dated September 7, 2021 (App. Ex. 3), and Dr. Lopez (App. Exs. 8-9). Applicant also requested judicial notice of the Order Approving Compromise & Release and Compromise & Release for ADJ2838078 (SBA 0080844) for $17,000.00 dated June 24, 1998, and Joint Stipulations With Request for Award for ADJ3992687 (LAO 0857256) and ADJ1284264 (OXN 0143929) stipulating to injury to the neck, right shoulder, right forearm, right elbow, right wrist and right hand for 11% permanent disability dated January 29, 2010.

In his report dated August 18, 2015, AME Dr. Fishman, after evaluating applicant, took a history that, after her reassignment from a supervisory role to a quality control inspector in summer 2014, she began performing more physically demanding duties and, within about two weeks, developed right elbow pain followed by left elbow pain. Her symptoms progressively worsened to include neck pain, bilateral elbow and forearm numbness and tingling, especially in the small and ring fingers, and increasing bilateral shoulder pain. (App. Ex. 1, p. 3.) AME Dr. Fishman's diagnostic impressions identified a pattern of cumulative occupational trauma and multiple prior work-related injuries affecting the cervical spine, shoulders, elbows, and right wrist. He concluded that applicant sustained a continuous injury from June 10, 2014 through April 21, 2015. This included reaggravation of a cervical sprain and strain with ongoing myofascial pain, bilateral

shoulder impingement, worse on the right, and bilateral elbow epicondylitis affecting both the medial and lateral sides. He also noted possible bilateral cubital tunnel syndrome. He deferred any psychiatric issues to the appropriate specialty. He also diagnosed earlier work-related injury periods from 2001 through 2010, noting repeated aggravations of cervical strain, right shoulder impingement, cubital tunnel syndrome, and right wrist conditions including De Quervain's tenosynovitis and synovitis, along with multiple prior surgical interventions to the right wrist, shoulder, and elbow. Overall, he concluded that successive occupational injuries and re-injuries have compounded chronic musculoskeletal and nerve-related conditions across multiple anatomical regions. (*Id.* at pp. 18-20.) He attributed applicant's injury to her cervical spine, shoulders and elbows to her exposure to cumulative trauma while employed by Waterway Plastics, Inc. (*Id.* at p. 20.)

In his report dated November 22, 2016, AME Dr. Fishman, after reevaluating applicant, assessed 18% whole person impairment (WPI) for the cervical spine based on DRE Category III (AMA Guides, Table 15-5, p. 392), due to significant signs of radiculopathy, including sensory loss in a dermatomal distribution, and electrodiagnostic studies verifying neurologic impairment. (App. Ex. 6, p. 41.)

AME Dr. Fishman assessed 7% WPI for the right upper extremity using the Range of Motion (ROM) method. For the right shoulder he measured abduction at 120° (3% upper extremity (UE) impairment), adduction at 40° (0% UE impairment), extension at 40° (1% UE impairment), flexion at 120° (4% UE impairment), internal rotation at 70° (1% UE impairment), and external rotation at 70° (0% UE impairment), yielding a total of 9% UE regional impairment (AMA Guides, Figures 16 40, 16-43, and 16-46, pp. 476, 477, and 479). For the right elbow he measured flexion at 130° (1% UE impairment), extension at 0° (0% UE impairment), pronation at 80° (0% UE impairment), and supination at 80° (0% UE impairment), yielding 1% UE regional impairment (AMA Guides, Figures 16-34 and 16-37, pp. 472 and 474). For the right wrist he measured flexion at 60° (0% UE impairment), extension at 50° (2% UE impairment), radial deviation at 20° (0% UE impairment), and ulnar deviation at 30° (0% UE impairment), yielding 2% UE regional impairment (AMA Guides, Figures 16-28 and 16-31, pp. 467 and 469). The sum of these regional impairments produced 12% total right UE impairment, which converts to 7% WPI (AMA Guides, Table 16-3, p. 439). (*Id.* at pp. 42-43.)

AME Dr. Fishman assessed 6% WPI for the left UE using the ROM method. For the left shoulder he measured abduction at 120° (3% UE impairment), adduction at 40° (0% UE impairment), extension at 40° (1% UE impairment), flexion at 140° (3% UE impairment), internal rotation at 80° (0% UE impairment), and external rotation at 70° (0% UE impairment), yielding a total of 7% UE regional impairment (AMA Guides, Figures 16-40, 16-43, and 16-46, pp. 476, 477, and 479). For the left elbow he measured flexion at 130° (1% UE impairment), extension at 0° (0% UE impairment), pronation at 80° (0% UE impairment), and supination at 80° (0% UE impairment), yielding 1% UE regional impairment (AMA Guides, Figures 16-34 and 16-37, pp. 472 and 474). For the left wrist he measured flexion at 60° (0% UE impairment), extension at 50° (2% UE impairment), radial deviation at 20° (0% UE impairment), and ulnar deviation at 30° (0% UE impairment), yielding 2% UE regional impairment (AMA Guides, Figures 16-28 and 16-31, pp. 467, 469).The sum of these regional impairments produced 10% total left UE impairment, which converts to 6% WPI (AMA Guides, Table 16-3, p. 439). (*Id.* at pp. 43-44.)

AME Dr. Fishman performed a pain assessment and added 3% WPI. He categorized applicant as having a Class II (moderate) impairment due to pain disorders (AMA Guides, Table 18-3, p. 575; Table 1-2, p. 4). He explained that this rating reflects her moderate pain severity and the resulting difficulty in managing instrumental activities of daily living (ADLs). (*Id.* at pp. 44-45.)

AME Dr. Fishman determined that, for the cervical spine, 50% is apportioned to the June 10, 2014 to April 21, 2015 date of injury, while 10% is apportioned to a March 27, 2001 injury, 15% to a March 30, 2006 injury, and 25% to a March 27, 2001 to January 29, 2010 date of injury. For the right shoulder, he apportioned 30% to the June 10, 2014 to April 21, 2015 date of injury and 70% to prior industrial factors, consisting of 10% for the March 27, 2001 injury, 10% for the March 30, 2006 injury, and 50% for March 27, 2001 to January 29, 2010 injury. For the right elbow and right wrist impairments, he apportioned 40% to the June 10, 2014 to April 21, 2015 date of injury, 50% to the March 27, 2001 to January 29, 2010 date of injury and 10% to the March 30, 2006 date of injury. Conversely, AME Dr. Fishman apportioned the left shoulder, left elbow and left wrist impairments to the March 27, 2001 to January 29, 2010 date of injury. (*Id.* at pp. 58-59.)

In his report dated August 19, 2022, QME Dr. Lopez, after evaluating applicant, concluded that she suffered from preexisting Major Depressive Disorder and Generalized Anxiety Disorder

prior to her subsequent cumulative injury. (App. Ex. 9, pp. 6, 16.) He rooted this preexisting impairment in her pronounced psychiatric symptoms dating back to 2011, noting that she experienced daily depression, severe anxiety, and panic-like symptoms that necessitated psychological therapy and a regimen of psychotropic medications including clonazepam, duloxetine, and quetiapine. (*Id.* at pp. 5, 6, 18.) He explained that these preexisting conditions were actively labor-disabling, resulting in a Global Assessment of Functioning (GAF) score of 60 and 15% WPI. (*Id.* at p. 18.) While she did not develop new psychiatric diagnoses following the subsequent cumulative injury, he determined that it severely exacerbated her existing anxiety and depression. (*Id.* at p. 6.) He highlighted her increased insomnia, social withdrawal, and intense focus on pain to support this deterioration, which ultimately reduced her GAF score to 55 and increased her overall psychiatric impairment to 23% WPI. (*Id.* at p. 18.)

In his supplemental report dated September 29, 2022, QME Dr. Lopez reviewed 66 pages of newly supplied Clinicas Del Camino Real records and reaffirmed his opinion that applicant suffered from preexisting Major Depressive Disorder and Generalized Anxiety Disorder. The records established that applicant experienced depressive episodes as early as 2004 and began psychiatric treatment with the antidepressant Celexa in 2011. (App. Ex. 9, p. 4.) He further highlighted that clinical screening questionnaires recorded just five days before the subsequent injury, a GAD-7 score of 11 and a PHQ-9 score of 10, demonstrated that she was already experiencing moderate anxiety and moderate depression immediately preceding the industrial event. (*Ibid.*) Reviewing post-injury records, QME Dr. Lopez observed that applicant's recurrent Major Depressive Disorder and Generalized Anxiety Disorder persisted with moderate to severe intensity following the subsequent injury. (*Id.* at p. 5.) Ultimately, he relied on this documented clinical history to reaffirm his conclusion that applicant sustained substantial psychiatric impairment both prior to and following the subsequent date of injury. (*Ibid.*)

In his report dated September 7, 2021, QME Dr. Ambrose, after evaluating applicant, concluded that applicant meets the statutory thresholds for SIBTF benefits. He concluded that applicant sustained a preexisting, labor-disabling permanent disability prior to her subsequent cumulative injury. He confirmed that this preexisting disability directly affects an extremity and that the combined industrial and nonindustrial impairment exceeds the 70% total disability threshold. Furthermore, he concluded that applicant is 100% permanently totally disabled and unemployable strictly due to the combined effects of her preexisting disabilities and her subsequent

work injury, explicitly noting she is not 100% disabled from the industrial injury alone. (App. Ex. 3, p. 3.)

Applicant provided a medical history outlining two specific periods of injury that antedate the subsequent cumulative injury. She reported falling in a strawberry field approximately 30 years prior to the evaluation, which caused bilateral knee injuries that she treated on an industrial basis and settled with a permanent disability award. (*Id.* at pp. 5-6.). Additionally, she sustained injuries to her neck and back during a 2004 motor vehicle accident, for which she received chiropractic treatment and experienced ongoing residual symptoms after her release. (*Id.* at p. 6.) Prior to the subsequent cumulative injury, applicant experienced significant ongoing subjective complaints. She reported constant preexisting neck and upper back pain characterized as a dull ache rated at 3/10. She described preexisting lower back pain with numbness and tingling radiating into both legs, rating this pain at 5–7/10 constantly and noting she wore a back brace on a near-daily basis. She also reported preexisting bilateral knee pain and stiffness that escalated to a 9–10/10 during provocative activities such as prolonged kneeling, crawling, and walking on uneven terrain (*Id.* at p. 7.)

In addition, QME Dr. Ambrose reviewed an extensive set of medical records spanning 2004 through early 2020. Those records included a 2004 motor vehicle accident note showing only transient neck and back pain that resolved with conservative care. Sporadic Clinicas Del Camino Real progress notes from 2009 to 2015 documented acute illnesses such as sore throat, bronchitis, and urinary-tract infections, along with self-reported anxiety and depression treated with medications such as Celexa begun in 2011, Zoloft, and occasional benzodiazepines. Scattered PHQ-9 and GAD-7 scores from late 2014 and early 2015 reflected moderate symptoms but contained no work restrictions. A remote strawberry-field fall had caused bilateral knee complaints that settled decades earlier with only a minor permanent disability award. The remaining records focused on post-2015 treatment for the subsequent cumulative injury (e.g., MRIs, EMGs, injections, and therapy notes). (*Id.* at pp. 30-67.)

QME Dr. Ambrose also outlined specific work restrictions for applicant based on both her subsequent cumulative injury and her preexisting conditions. For her subsequent injury, he restricted her from prolonged overhead work, repetitive pushing or pulling, and extended use of her elbows, wrists, and hands. For her preexisting spinal and bilateral knee conditions, he precluded her from prolonged sitting, standing, walking, bending, heavy lifting, squatting,

kneeling, and traversing uneven terrain. Relying on his clinical experience, QME Dr. Ambrose concluded that these combined limitations restricted her to working a maximum of three to four hours a day for no more than three days a week, rendering her permanently and totally disabled. (*Id.* at pp. 26-27.)

QME Dr. Ambrose assessed 6% WPI for the cervical spine based on DRE Category II (AMA Guides, Table 15-5, p. 392) and 8% WPI for the thoracic spine based on DRE Category II (AMA Guides, Table 15-4, p. 389). DRE Category II applies when the history and findings are compatible with a specific injury and include intermittent or continuous muscle guarding observed by a physician, asymmetric loss of ROM, or nonverifiable radicular complaints, yet there is no objective evidence of radiculopathy or loss of structural integrity. He apportioned 75% of the cervical impairment to preexisting causation and 25% to the subsequent cumulative injury, while apportioning 100% of the thoracic impairment to preexisting causation. (Id. at pp. 17, 22, 25.)

Utilizing the ROM method for the lumbar spine due to multilevel radiculopathy, QME Dr. Ambrose calculated 8% WPI for disorder impairment, consisting of 7% WPI pursuant to Category II-C and 1% WPI for an additional level of involvement (Category II-F) (AMA Guides, Table 15-7, p. 404.) (*Id.* at pp. 22-23.)

He further assessed ROM impairment as follows: 5% WPI for a sacral (hip) flexion angle range of 0–29° with a true lumbar flexion angle of 30° or greater, and 7% WPI for true lumbar extension of 2° from neutral. (AMA Guides, Table 15-8, p. 407.) He measured right lateral flexion at 7° (4% WPI) and left lateral flexion at 14° (2% WPI). (AMA Guides, Table 15-9, p. 409). The sum of these values yielded a total ROM impairment of 18% WPI. (*Ibid.*)

He then calculated the bilateral sensory and motor nerve impairments for the L5 and S1 nerve roots by, for the sensory impairment, applying a 25% grading multiplier, corresponding to a Grade 4 sensory deficit (AMA Guides, Table 15-15 on page 424), and multiplied it by the 5% maximum sensory nerve value for both the L5 and S1 nerve roots (AMA Guides, Table 15-18, p. 424.) This calculation yielded a 1.25% impairment, which he rounded down to assign a 1% sensory impairment for each nerve root on the lower left and lower right sides. To evaluate the motor impairment, he applied the same 25% grading multiplier, corresponding to a Grade 4 motor deficit (AMA Guides, Table 15-16, p. 424), and multiplied it by a 20% maximum motor value for the L5 and S1 nerve roots. (AMA Guides, Table 15-18, p. 424.) This calculation produced a 5% motor

impairment for each nerve root bilaterally. This resulted in 7% lower extremity (LE) impairments bilaterally converted to 3% WPI (AMA Guides, Table 17-3, p. 527). (*Ibid.*)

He then combined the musculoskeletal impairments (8% WPI) with the ROM impairment (18% WPI) with the sensory and motor nerve impairments (3% WPI each) using the Combined Values Chart (CVC) to reach 29% WPI apportioning 100% of the impairment to preexisting nonindustrial causes. (*Id.* at pp. 22-23, 29.)

For the right shoulder, in determining ROM impairment, he calculated 75° of flexion (7% UE impairment) and 40° of extension (1% UE impairment). (AMA Guides, Figure 16-40, p. 476.) He next calculated 76° abduction (5% UE impairment) and 21° adduction (1% UE impairment). (AMA Guides, Figure 16-43, p. 477.) Finally, he calculated 40° internal rotation (3% UE impairment) and 28° external rotation (1% UE impairment). (AMA Guides, Figure 16-46, p. 479.) When summed, it equaled 18% UE impairment or 11% WPI. (AMA Guides, Table 16-3, p. 439.) In determining strength impairment, he found, for shoulder flexion and abduction, 4/5 strength which was significant enough to use the more severe column (30% to 50% category). (AMA Guides, Table 16-35, p. 510.) For flexion, he chose the upper end of that range: 12% UE impairment and, for abduction, he chose the upper end: 6% UE impairment. Summed together, they equal 18% UE impairment or 11% WPI. (AMA Guides, Table 16-3, p. 439.) Combining the ROM impairment of 11% WPI and the strength impairment of 11% WPI per the CVC equals 21% WPI apportioned entirely to the subsequent cumulative injury. (*Id.* at pp. 14, 18, 25.)

For the left shoulder, in determining ROM impairment, he calculated 80° of flexion (7% UE impairment) and 29° of extension (1% UE impairment) (AMA Guides, Figure 16-40, p. 476.) He next calculated 61° abduction (6% UE impairment) and 26° adduction (1% UE impairment). (AMA Guides, Figure 16-43, p. 477.) Finally, he calculated 38° internal rotation (3% UE impairment) and 38° external rotation (1% UE impairment). (AMA Guides, Figure 16-46, p. 479.) When summed, it equals 19% UE impairment or 11% WPI. (AMA Guides, Table 16-3, p. 439.) He calculated the same strength impairment to 11% WPI. When summed, they result in 21% WPI apportioned entirely to the subsequent cumulative injury. (*Id.* at pp. 14, 19, 25.)

With respect to the elbows, wrists and hands, he assessed no permanent disability under the strict application of the AMA Guides but, pursuant to *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc), he applied by analogy impairment based on loss of grip or pinch

strength. He supported this deviation due to applicant's significant pain on a frequent to constant basis and a marked compromise in her ability to function and ADLs, including being unable to do most recreational activities. He measured with a calibrated J-Tech dynamometer applicant's maximum grip strength as 13 pounds on the right and 8 pounds on the left out of an average normal of 65 pounds. He then calculated the "Strength Loss Index" using the following formula:

Normal strength – Limited strength = Strength loss
Normal strength index %

Right: (65 – 13) / 65 = 80% loss
Left: (65 – 08) / 65 = 88% loss.

Converting the above percentage of loss index resulted in 30% UE impairment (18% WPI) bilaterally (AMA Guides, Table 16-34, p. 509; Table 16-3, p. 439) which he apportioned entirely to the subsequent cumulative injury. (*Id.* at pp. 12, 20-21, 25.)

With respect to combining the various WPIs, QME Dr. Ambrose opined that, in accordance with *Athens Administrators v. Workers' Comp. Appeals Bd*. (*Kite*) (2013) 78 Cal.Comp.Cases 213 (writ denied) (*Kite*)[1], the shoulders, wrist and hands should be added together rather than combined via CVC due to the synergistic effects of the concurrent bilateral impairments. (*Id.* at p. 27.) He also recommended adding together the impairments for the thoracic and lumbar spine, and separately adding together the impairments for the knees. (*Id.* at p. 28.)

For the right knee, in determining ROM impairment, he calculated 89° of flexion equating to 10% LE impairment (4% WPI). (AMA Guides, Table 17-10, p. 537.) In determining muscle weakness, he determined Grade 4 for both flexion and extension equating to 12% LE impairment (5% WPI). (AMA Guides, Table 17-8, p. 532.) Finally, he assessed 5% LE impairment (2% WPI) based on a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on X-rays. (AMA Guides, Table 17-31, p. 544.) He used the CVC to reach 11% WPI and apportioned it entirely to preexisting nonindustrial causes. (*Id.* at pp. 24-25.)

For the left knee, in determining ROM impairment, he calculated 93° of flexion equating to 10% LE impairment (4% WPI). (AMA Guides, Table 17-10, p. 537.) The remaining calculations

[1] We note that *Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686 (Appeals Board en banc) has now superseded *Kite*.

mirrored those of the right knee and summed to 11% WPI that he apportioned entirely to preexisting nonindustrial causes. (*Id.* at pp. 24-25.)

On May 10, 2023, the WCJ issued her Findings, concluding that applicant failed to establish her eligibility for SIBTF benefits.

It is from this Finding that applicant seeks reconsideration.

DISCUSSION

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

Labor Code section 4751[2] provides that if an employee with a preexisting permanent partial disability suffers a new compensable injury that increases their total disability beyond what the new injury alone would cause, and the combined permanent disability equals 70% or more, the employee is entitled to additional compensation for the portion of disability exceeding the last injury. This applies when the new injury alone, without adjustment for occupation or age, causes 35% or more permanent disability, or when the preexisting disability affected a limb or eye and the new injury, without adjustment for occupation or age, affects the opposite corresponding limb with at least 5% permanent disability on its own. (Lab. Code, § 4751.)

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

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.)

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

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.)

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

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

However, a retroactive prophylactic work restriction determined after the industrial injury does not establish permanent disability or impairment before the injury unless substantial evidence demonstrates that the employee had work restrictions beforehand. (*Franklin*, *supra*, 79 Cal.App.3d at p. 238; *Escobedo, supra,* 70 Cal.Comp.Cases at p. 619.) Such evidence may include an actual prophylactic work restriction before the industrial injury. (*Franklin*, *supra*, 79 Cal.App.3d at

p. 238.) Applying a retroactive prophylactic work restriction which is not supported by substantial evidence creates a factual or legal fiction of an otherwise nonexistent previous disability or physical impairment. (*Ibid.*) Instead, there must be substantial medical evidence establishing permanent disability or impairment independent of any retroactive prophylactic work restrictions. (*Allen*, *supra*, 56 Cal.2d at p. 846; *Franklin*, *supra*, 79 Cal.App.3d at p. 391.)

We further note that a Compromise and Release is not a finding of permanent disability. (*Evans v. San Francisco 49ers* [2024 Cal. Wrk. Comp. P.D. LEXIS 357, *9-10]; *Eugenio v. Subsequent Injuries Benefits Trust Fund* [2024 Cal. Wrk. Comp. P.D. LEXIS 217, *1-2]; *Daniels v. Subsequent Injuries Benefits Trust Fund* [2024 Cal. Wrk. Comp. P.D. LEXIS 72, *4]; *Glover v. New Orleans Saints* [2023 Cal. Wrk. Comp. P.D. LEXIS 273, *6]; *Humphrey v. Subsequent Injuries Benefits Trust Fund* [2023 Cal. Wrk. Comp. P.D. LEXIS 234, *6-7].)[3] In addition, Stipulations with Request for Award not involving SIBTF cannot bind it to a finding of disability nor can they constitute a "substitute for proof." (*Macias v. Subsequent Injuries Benefits Trust Fund* [2022 Cal. Wrk. Comp. P.D. LEXIS 363, *17].)

Finally, the law requires the Appeals Board to base its decisions on substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) To constitute substantial evidence, a medical opinion must state its conclusions in terms of reasonable probability, avoid speculation, rely on pertinent facts and an adequate examination and history, and explain the reasoning supporting its conclusions. (*Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 621.) Medical 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 opinion cannot support the Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169

[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.

[36 Cal.Comp.Cases 93].) Accordingly, the Board may reweigh the evidence and reach a decision different from the WCJ's determination when other evidence of substantial probative value supports a contrary conclusion. (*Lamb*, *supra*, 11 Cal.3d at p. 281; *Garza*, *supra*, 3 Cal.2d at pp. 318-319.)

In the present case, the opinions of QME Dr. Lopez and QME Dr. Ambrose both fail to constitute substantial medical evidence sufficient to establish the preexisting permanent partial disability required for SIBTF eligibility under section 4751. Both physicians assert that applicant harbored labor-disabling impairments before the subsequent cumulative injury, yet neither supplies the objective, corroborated, and temporally anchored evidence necessary to prove that those impairments actually limited her earning capacity or her ability to perform her regular full-duty work as a quality-control inspector at the time she sustained the subsequent injury.

QME Dr. Ambrose's September 7, 2021 report assigns 29% WPI to the lumbar spine and 11% WPI to each knee, attributing all of it to preexisting factors. Although he performed inclinometer measurements during a post-injury exam, those findings are limited and imprecise: sacral/hip flexion is reported only within the broad 0–29° category, true lumbar flexion measures 30° or greater, extension is just 2° from neutral (AMA Guides, Table 15-8, p. 407), and lateral flexion values are interpolated. (AMA Guides, Table 15-9, p. 409.) More importantly, he obtained these measurements on May 28, 2020, over five years after the subsequent injury, so they reflect applicant's condition long after the cumulative trauma occurred.

The report never identifies or even references any pre-April 21, 2015 objective data, such as inclinometry, ROM measurements, electrodiagnostic studies, or functional-capacity evaluations, that would show the same lumbar or knee deficits existed earlier and were labor-disabling while applicant was still working full duty. This same lack of evidence undermines his knee ratings as well. Because the measurements only document post-injury impairment, they cannot establish that the conditions were disabling before the cumulative trauma.

Even the extensive pre-2015 records he summarizes fail to fill this gap. They consist largely of self-reported anxiety and depression treated intermittently with medication, routine non-orthopedic issues like sore throats, bronchitis, and urinary tract infections, and a remote strawberry field knee injury that resolved decades earlier with only a minor permanent disability award. None of these records include goniometric data, strength testing, or functional-capacity evaluations demonstrating that any lumbar, knee, or psychiatric condition impaired applicant's

earning capacity or prevented her from performing full-duty work as a quality-control inspector through April 21, 2015.

Furthermore, QME Dr. Ambrose's attempt to impose preexisting work restrictions for the cervical spine, thoracic spine, lumbar spine and knees retroactively fails the legal standard for SIBTF eligibility because he formulates these limitations years after the fact without providing any contemporaneous, objective evidence that they impaired applicant's earning capacity before April 21, 2015. Because QME Dr. Ambrose bases his preexisting restrictions on his current post-injury examination rather than objective, pre-injury functional evaluations or actual pre-injury work restrictions, his conclusions rest on conjecture.

QME Dr. Lopez's August 19, 2022 report and September 29, 2022 supplemental report fare no better. He assigns 15% WPI to a preexisting Major Depressive Disorder and Generalized Anxiety Disorder based primarily on applicant's self-reported treatment beginning in 2011 and scattered PHQ-9 and GAD-7 screening scores from late 2014 and early 2015. These screening instruments, standing alone, do not demonstrate permanent impairment that actually interfered with applicant's ability to perform her regular work duties before April 21, 2015. The supplemental report merely recites the newly supplied Clinicas records confirming sporadic medication management and counseling, but contains no analysis showing that the documented symptoms translated into a competitive handicap in the open labor market or a loss of earning capacity at the time of the subsequent injury. Applicant continued working full duty until the very day the subsequent cumulative trauma claim accrued. Absent objective evidence, such as pre-injury work restrictions or corroborated functional limitations in ADLs that actually affected her job performance, QME Dr. Lopez's conclusions also rest on conjecture rather than substantial medical evidence.

Because neither QME has demonstrated, with the degree of medical probability and objective corroboration required by law, that applicant suffered from a labor-disabling permanent partial disability before the subsequent injury of April 21, 2015, their reports cannot support SIBTF entitlement.

The Compromise and Release dated June 24, 1998 and the Stipulations with Request for Award dated January 29, 2010 are likewise unavailing. The former resolved an alleged 1996 injury to the spine and right knee for $17,000.00 with no formal adjudication of permanent disability, while the latter stipulated to an 11% permanent disability rating for the neck, right shoulder, right

forearm, right elbow, right wrist, and right hand solely between applicant and the respective insurance carrier. Neither of the documents constitutes a judicial finding of permanent disability, nor does either establish that any preexisting impairment was labor disabling at the time of the subsequent cumulative injury. Stipulations and Compromise & Releases bind only the signatories and cannot substitute for the independent, substantial medical evidence required to prove preexisting labor-disabling permanent partial disability required under section 4751.

Here, the WCJ found that applicant met the initial threshold for benefits under section 4751. No party challenged that finding. However, as explained above, it is not clear on this record that applicant met the initial threshold. Thus, further development of the record may be appropriate.

Accordingly, as our Decision After Reconsideration, we rescind the May 10, 2023, Findings and return the matter to the WCJ for further proceedings consistent with this decision. When the WCJ issues a new decision, any aggrieved person may timely seek reconsideration.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings of Fact issued on May 10, 2023 by the WCJ is **RESCINDED** and the matter is **RETURNED** to the WCJ for further proceedings consistent with this decision.

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG L SNELLINGS, COMMISSIONER

I CONCUR,

/s/ ANNE SCHMITZ, DEPUTY COMMISSIONER

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

JULY 15, 2026

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

SILVIA FERNANDEZ
GHITTERMAN, GHITTERMAN & FELD
OFFICE OF THE DIRECTOR – LEGAL UNIT (LOS ANGELES)

DLP/md

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