WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

GABRIEL ROGERS, *Applicant*

vs.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION; legally uninsured, administered by State Compensation Insurance Fund, *Defendants*

Adjudication Number: ADJ12129088
Marina Del Rey District Office

OPINION AND DECISION
AFTER RECONSIDERATION

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

Defendant seeks reconsideration of the Amended Findings and Award (F&A) issued on April 29, 2026, wherein the workers' compensation administrative law judge (WCJ) found, in relevant part, that applicant, while employed as a parole agent during the period February 18, 1991 to November 20, 2018, sustained industrial injury to his cervical and lumbar spine, bilateral shoulders and knees, upper gastrointestinal system, ear/hearing, psyche and in the form of bilateral carpal tunnel, resulting in temporary disability during the period from February 18, 1991 to November 20, 2018, and resulting in 100% permanent disability.

Defendant contends[1] that the Panel Qualified Medical Evaluator (PQME) Allen H. Lee, M.D., found that the psyche injury was not predominantly caused by actual events of employment and therefore does not meet the threshold for causation pursuant to Labor Code section 3208.3(b)(1)[2] and the WCJ erred in finding it industrial. Defendant further contends that the WCJ erred in adding the permanent disabilities in accordance with *Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686 (Appeals Board en banc) (*Vigil*) and the opinion of the Agreed Medical

[1] Defendant filed a supplemental petition for reconsideration dated June 8, 2026 withdrawing its challenge to the finding regarding temporary disability.

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

Evaluator (AME) of Isaac Schmidt, M.D., and failed to apportion prior permanent disability from a 42% stipulated award dated February 6, 2019 (ADJ7507084) in accordance with section 4664 and *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1115 [71 Cal.Comp.Cases 1229] (*Kopping*).

Finally, defendant contends that the WCJ erred in admitting the supplemental report of Jonathan Nissanoff, M.D., dated November 18, 2025 (App. Ex. 2) into evidence because it was obtained after the mandatory settlement conference on October 10, 2023.

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

FACTS

Applicant, while employed as a parole agent during the period February 18, 1991 to November 20, 2018, sustained industrial injury to his cervical and lumbar spine, bilateral shoulders and knees, upper gastrointestinal system, and in the form of bilateral carpal tunnel and claims to have sustained industrial injury to his ear/hearing and psyche. (Minutes of Hearing and Summary of Evidence (MOH/SOE), 01/18/2024, 2:4-9.)

On February 6, 2019, in ADJ7507084, the parties entered into stipulations with request for award that applicant, on February 22, 2010, sustained an industrial injury to his neck, right shoulder, right elbow, heart, psyche, and in the form of gastroesophageal reflux disease resulting in 42% permanent disability. (Def. Ex. R, ¶¶1, 3.) The parties also agreed as follows:

> PARTIES STIPULATE THAT (PD) IS 42% FlNAL PD SPLIT OF 45%
> AND 39%:
> [Shoulder – Other]
> 16.02.02.00-11-[7]15-490I-21-21;
> [Central & Peripheral Nervous System - Arousal Disorder]
> 70% (13.03.00.00-8-[6]11-490I-16-16)11;
> [Cardiovascular System - Arrhythmia]
> 03.06.00.00-5-[5]6-490I-9-9;
> [Mental and Behavioral (Psychiatric)]
> 95% (14.01.00.00-3-[8] 4-490J- 8-8) 8;

[Digestive System - Upper Digestive Tract]
06.01.00.00-5-[6]7-490F-7-7;

FINAL PD IS 42% BASED ON AME REPORTS OF DR. SCHMIDT 05/01/17; DR. CAREN 08/14/13; DR. ALLEN LEE 02/07/18; DR. FINK 05/08/13 & 10/16/17.

(Def. Ex. R, ¶9.)

On January 18, 2024, the parties proceeded to trial on, among other issues, parts of body injured, temporary and permanent disability. (MOH/SOE, 01/18/2024, 2:21-25 to 3:1-8.) Trial proceedings continued on September 18, 2025 and February 3, 2026.

The parties jointly submitted into evidence the PQME reports of Dr. Lee (Joint Exs. A1-G1), AME reports of Dr. Schmidt dated January 8, 2021 to December 23, 2023 (Joint Exs. H1-O1), Graham M. Woolf, M.D. (Joint Exs. P1-R1), Ezekiel Fink, M.D. dated August 30, 2023. (Joint Ex. S1), and Robert Ruder, M.D. (Joint Exs. T1-A2.) Defendant submitted into evidence AME reports of Jeffrey F. Caren, M.D. (Def. Exs. A-D), Dr. Fink dated November 12, 2020 (Def. Ex. E), and Dr. Schmidt dated July 19, 2011 to November 4, 2020 (Def. Exs. F-L), as well as Stipulations with Request for Award for ADJ7507084 dated February 6, 2019 for a February 22, 2010 date of injury. (Def. Ex. R.)

Applicant's testimony detailed his physical and psychological stressors stemming from his employment duties as a parole agent and defensive tactics instructor. He began his career as a correctional officer on February 18, 1991, before transitioning to parole agent II in 2007 to 2008. (Transcript, 01/18/2024, 20:22-25 to 21:1-21.) His physical workload increased substantially after returning to work in 2014. (Transcript, 01/18/2024, 11:23-25 to 1:1-8.) Specifically, fellow officers repeatedly executed arm-bar takedowns on him during hand-to-hand combat training, using him as the demonstration dummy and forcefully driving him to the ground. (Transcript, 01/18/2024, 12:9-25 to 13:1-11.) Additionally, he wore heavy protective gear weighing 20 to 25 pounds daily. (Transcript, 01/18/2024, 17:15-22.) He also noted gradual hearing loss from extended time at the firing range. (Transcript, 01/18/2024, 12:14-17.) Following a medical leave, administrator Jamal Rowe instructed applicant to remain home without his state vehicle or computer, effectively ending his active duty prior to his formal retirement. (Transcript, 01/18/2024, 13:22-25 to 14:1-7.)

Addressing his physical impairments, the cold weather exacerbates his wrist pain and causes his hands to fall asleep, which required his wife to drive him to the hearing. (Transcript, 01/18/2024, 11:12-17.) He modified his behavior to avoid double knob doors and experienced

diminished grip strength resulting in dropped coffee cups. (Transcript, 01/18/2024, 14:22-25 to 15:1-3.) He explained that his neck and hand symptoms deteriorated further, restricting him from driving long distances and forcing him to tape old wrist braces together at night to manage throbbing pain. (MOH/SOE, 09/18/2025, 3:21-25 to 4:1.) He described severe difficulties with basic self-care noting he must switch hands while brushing his teeth, utilizes elastic hooks to dress, and occasionally jumps into the shower because back pain prevents him from cleaning himself after using the toilet. (MOH/SOE, 09/18/2025, 4:13-19.) Although his physician authorized lifting 40 pounds, lifting a 38-pound bag of salt left him bedridden the following day. (MOH/SOE, 09/18/2025, 5:7-8.) He experiences constant stabbing pain in his back and a sensation of spiders crawling on his skin. (MOH/SOE, 09/18/2025, 6:1-3.) Invoking a theory from the late AME Dr. Schmidt, he described applicant's body as a puzzle where an injury to one part, such as his knees or lower back, triggers guarding movements that cascade into pain across his hips, shoulders, and neck. (MOH/SOE, 09/18/2025, 6:7-11.)

Regarding his psychiatric injury and quality of life, he gained 30 to 40 pounds due to an inability to engage in cardiovascular exercise. (Transcript, 01/18/2024, 15:15-18.) He expressed profound fear for his personal safety after encountering a family member of a former arrestee at a warehouse store, prompting him to question whether he could physically protect his wife and four children. (Transcript, 01/18/2024, 18:2-12, 18:19-22, 19:4-16.) This specific safety concern, combined with his physical vulnerabilities, prompted him to relocate his family to Idaho in June 2024. (MOH/SOE, 09/18/2025, 4:2-7, 5:15-16.) Despite relocating, he remains hypervigilant and constantly assesses strangers to determine if they pose a threat. (MOH/SOE, 09/18/2025, 6:22-25.) Furthermore, he experiences untreated erectile dysfunction, which damages his marital relationship. (MOH/SOE, 09/18/2025 5:10-11.) These compounding physical failures leave him feeling that he is not the man he once was and prevent him from living the life he imagined. (MOH/SOE, 09/18/2025, 4:6-7, 6:4-6.)

On February 3, 2026, the parties returned to trial. Applicant sought to introduce the supplemental medical-legal report of Dr. Nissanoff dated November 18, 2025 (App. Ex. 2) to address adding the permanent disabilities in accordance with *Vigil* and because Dr. Schmidt died on February 2, 2025. (Minutes of Hearing, 02/03/2026, 2:13-15; Report, 06/04/2026, p. 2.)

In his deposition dated December 23, 2025, Mr. Rowe testified that he serves as the Chief of Sacramento County Probation, having previously worked for the California Department of

Corrections and Rehabilitation within the Division of Adult Parole Operations beginning in November 2002. (Def. Ex. Y, pp. 6:16-25 to 7:1-7.) In May 2018, he received his promotion to Parole Administrator over the Electronic Monitoring Unit, where he managed global positioning system contracts and oversaw 10 to 12 peace officers. (*Id.* at pp. 8:20-22, 9:8-20.) In this capacity, Mr. Rowe operated two levels above applicant in the chain of command, with Mr. Rowe based in Northern California and applicant stationed in Southern California. (*Id.* at pp. 10:12-21, 23:23-25.) Mr. Rowe considered applicant a knowledgeable leader, maintained no personal problems with him, and testified that he treated applicant fairly. (*Id.* at p. 21:9-22.)

Following his promotion to Parole Administrator, Mr. Rowe held hiring authority for out-of-class Parole Agent III positions and recalled a permanent position opening, though he did not remember whether applicant applied or formally expressed interest. (*Id.* at pp. 12:2-14; 13:2-25 to 14:1-2.) Mr. Rowe acknowledged a vague conversation with applicant regarding retirement but explicitly denied asking him when he planned to retire or making a disparaging remark about him taking his ball and going home. (*Id.* at pp. 14:5-20, 15:17-23.) Mr. Rowe supported retirement as an achievable accomplishment and denied instructing applicant to stay home and answer calls between April 14, 2019 and May 31, 2019. (*Id.* at pp. 15:24-25 to 16:1-13.)

Following applicant's retirement, Mr. Rowe learned from a contractor, likely Greg Utterback or Odell Romero, that applicant performed contract work for Securus, a company holding a monitoring contract with the Division of Adult Parole Operations. (*Id.* pp. 16:14-23, 17:10-25 to 18:1-2, 18:23-25 to 19:1-3.) Acting under a contract clause requiring his approval for personnel working on Department matters, Mr. Rowe instructed Securus that applicant should not work on the Division of Adult Parole Operations contract. (*Id.* at pp. 18:3-9; 19:5-9.) Mr. Rowe took this action because a Southern California judge contacted applicant for expert testimony regarding the monitoring program, and Mr. Rowe determined that current subject matter experts, rather than a retired employee, must provide such testimony on behalf of the state. (*Id.* at pp. 19:18-25 to 20:1-5; 29:4-25.) Mr. Rowe contacted the judge directly to advise that applicant had retired, but Mr. Rowe denied instructing Securus to terminate applicant's overall employment or preventing him from working on other contracts outside of the Division of Adult Parole Operations. (*Id.* at pp. 20:9-16, 21:1-8; 30:18-22.)

In his report dated July 1, 2011, AME Dr. Caren, after evaluating applicant in the field on internal medicine, recorded objective physical findings on July 1, 2011, including a regular pulse

of 65, blood pressure of 120/80, a normal echocardiogram, and an abnormal lipid panel demonstrating a cholesterol level of 245 and LDL of 159. (Def. Ex. D, pp. 7, 9.) In his report dated August 14, 2013, AME Dr. Caren documented objective physical findings of a regular pulse of 62, a blood pressure of 120/84, a normal electrocardiogram, and an abnormal comprehensive metabolic panel showing a BUN of 31 and a calcium level of 7.8. (Def. Ex. C, pp. 7-8.) In both reports, the abdominal and cardiovascular physical examinations remained generally unremarkable without masses, tenderness, murmurs, or adventitious sounds during both evaluations (Def. Ex. D, p. 8; Def. Ex. C, pp. 7-8.)

AME Dr. Caren diagnosed applicant with gastritis and a heart arrhythmia characterized as a single episode of atrial fibrillation with palpitations. (Def. Ex. D, p. 19; Def. Ex. C, p. 18.) AME Dr. Caren assessed 5% whole person impairment (WPI) for the gastritis. (AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), Table 6-3, Class 1, p. 121.) (Def. Ex. D, p. 19; Def. Ex. C, p. 19.) He supported his assessment based on occasional symptoms of abdominal burning requiring medical treatment, specifically the use of Prilosec and milk for relief. (Def. Ex. D, p. 4; Def. Ex. C, p. 4.) Applicant exhibited no physical signs of upper digestive tract disease, lacked evidence of anatomic loss, did not require continuous treatment, and maintains a desirable weight. (Def. Ex. D, p. 19; Def. Ex. C, p. 19.)

AME Dr. Caren assessed 5% WPI for the cardiac arrhythmia. (AMA Guides, Table 3-11, Class 1, p. 56.) He explained that, although the initial acute rhythm disturbance had resolved, applicant remained at risk for future episodes and continued to experience occasional subjective palpitations approximately once a month. Because his current symptoms were minor, he remained asymptomatic during ordinary activities and exhibited no measurable impairment in activities of daily living (ADLs). (Def. Ex. D, p. 21; Def. Ex. C, p. 21.)

In his report dated July 19, 2011, AME Dr. Schmidt, after evaluating applicant in the field of orthopedics, took a history that, on February 22, 2010, he sustained a right shoulder injury when, while he was lifting an eight-foot-long table, it started to fall, causing him to catch the table and experience a pulling sensation to his right shoulder. (Def. Ex. L, p. 2.)

In his supplemental report dated May 1, 2017, AME Dr. Schmidt assessed, for the February 22, 2010 date of injury to the right shoulder, 6% whole person impairment, based on a range of motion (ROM) deficit. He measured maximum forward flexion at 170° (1% upper extremity (UE) impairment) and maximum extension at 30° (1% UE impairment). (AMA Guides

for the Evaluation of Impairment (AMA Guides), Figure 16-40, p. 476.) He further measured maximum abduction angle at 90° (4% UE impairment) and maximum adduction at 20° (1% UE impairment). (AMA Guides, Figure 16-43, p. 477.) Finally, he measured maximum external rotation at 30° (1% UE impairment) and maximum internal rotation at 60° (2% UE impairment). Together, these deficits yielded a combined 10% UE impairment, which converts to 6% WPI. (AMA Guides, Table 16-3, p. 439.) (Def. Ex. I, pp. 7-8.)

In his report dated November 4, 2020, AME Dr. Schmidt conducted a telehealth re-evaluation of applicant on August 3, 2020, to address the February 18, 1991 to November 20, 2018 injury. Applicant reported experiencing intermittent cervical spine pain radiating to his shoulders, accompanied by tingling and numbness extending into the hands and fingers. He further described bilateral wrist and hand pain with cramping, constant lumbar spine pain radiating down the posterior lower extremities to the feet, abdominal region pain associated with a hernia, and bilateral anterior knee pain aggravated by prolonged standing and walking. (Def. Ex. F, p 11.) AME Dr. Schmidt completed the physical examination remotely, noting applicant's reports of persistent cervical pain radiating to the left shoulder and acromioclavicular joint. The remote neurological examination revealed decreased sensation in the ulnar nerve distribution, which AME Dr. Schmidt attributed to the cubital tunnel rather than cervical radiculopathy. Following a review of the diagnostic history and the onset of bilateral upper extremity symptomatology subsequent to prior surgeries, he concluded that a medical basis existed to support cumulative trauma. (*Id.* at p. 13.)

In his October 5, 2021 report, AME Dr. Schmidt conducted a telehealth re-evaluation of applicant and documented persistent subjective complaints involving the cervical spine, bilateral shoulders, bilateral elbows, bilateral wrists and hands, lumbar spine, bilateral knees, and gastrointestinal system. (Joint Ex. N1, p. 7.) Applicant reported cervical spine pain rated at 4–5/10, with flare-ups reaching 7/10 and radiating into the shoulders with tingling in the hands and fingers. He described right shoulder pain rated at 1–2/10, increasing to 6/10 during flare-ups, while left shoulder pain flared to 5–6/10, with both shoulders producing radiating pain and numbness into the biceps. Applicant also reported bilateral elbow pain rated at 8/10 with activity, bilateral wrist and hand pain ranging from 5–6/10 with occasional thumb locking, lumbar spine pain rated at 7/10 that increased to 9/10 after standing or walking for 10 minutes, intermittent bilateral knee pain, and abdominal pain ranging from 3–7/10 that worsened with bending or lifting. (*Id.* at pp. 9-10.) During the virtual examination, AME Dr. Schmidt identified persistent cervical spine pain

with sensory deficits in the C5 nerve root distribution, persistent lumbar pain radiating into the right lower extremity with sensory deficits in the S1 nerve root distribution, significant improvement of the left shoulder, and persistent residual impairment of the right shoulder characterized by pain, popping, and grinding. (*Id.* at p. 11.)

In his January 6, 2022 report, AME Dr. Schmidt conducted an in-person evaluation of applicant on December 7, 2021, and documented a marked increase in multiple subjective complaints compared to the prior telehealth assessment. Applicant reported worsening cervical spine symptoms, with baseline pain increasing from 4–5/10 to intermittent levels of 6–7/10, accompanied by new numbness extending into the hands and fingers. His right shoulder symptoms also worsened, increasing from a baseline of 1–2/10 to intermittent pain levels of 6–7/10. Similarly, left shoulder pain increased to 6–7/10, with new nocturnal numbness disrupting sleep and unusual radiation into the right arm. (Joint Ex. M1, p. 80.)

He described significant lumbar spine deterioration, with frequent baseline pain increasing to 8–9/10 and positional flare-ups reaching 10/10. He reported new lower extremity numbness causing gait instability and recent falls, as well as increased bilateral wrist and hand pain from a prior maximum of 6/10 to a current peak of 6–7/10. He further reported new cramping, weakness, and numbness involving the index and middle fingers. (*Ibid*.)

He also clarified his previously generalized knee complaints, reporting right knee pain at 4-5/10 with prolonged standing and left knee pain at 1–3/10 with new intermittent swelling. (*Id.* at p. 81.) Bilateral elbow and abdominal complaints remained unchanged from the prior evaluation. (*Id.* at pp. 80-81.)

During the objective physical examination, AME Dr. Schmidt documented bilateral medial patellar tenderness, anteromedial joint line tenderness, and pain upon quadriceps compression. (*Id.* at pp. 83-84.) The lumbar spine evaluation demonstrated decreased lordosis, tenderness spanning the fourth lumbar vertebra through the first sacral vertebra, and restricted range of motion, with forward flexion limited to 30° and extension limited to 20°. (*Id.* at p. 84.) Upper extremity testing yielded positive Phalen and Tinel signs bilaterally. (*Id.* at p. 86.) Cervical spine palpation exposed muscle spasm and tenderness at the fifth through seventh cervical vertebrae, while range of motion exhibited restriction to 30° in flexion and 20° in extension. (*Id.* at pp. 86-87.) He observed intermittent sensory deficits along the fifth and sixth cervical nerve roots in the right arm. (*Id.* at p. 87.) The shoulder examination identified bilateral

acromioclavicular joint prominence and tenderness, alongside positive empty can testing on the right side. (*Id.* at pp. 87-88.) He additionally noted four out of five strength deficits in right shoulder abduction, internal rotation, and extension, coupled with right deltoid numbness and four well-healed surgical scars across both shoulders. (*Id.* at pp. 88-89.)

He assigned 13% WPI for the cervical spine, supported objectively by neck pain radiating to the shoulders, tingling and numbness in the hands and fingers, palpable muscle spasms in the bilateral trapezius, sternocleidomastoid, and paraspinal cervical muscles, and a dermatomal sensory deficit at C5-C6 in the right arm. (AMA Guides, Table 15-5, Category III, p. 392.) (*Id*. at pp. 86, 89-90.) However, in his supplemental report dated June 26, 2023, he corrected it to 15% WPI. (Joint Ex. J1, p. 5.)

He assigned 8% WPI for the lumbar spine, substantiated by frequent 8-9/10 pain with flare-ups, restricted lumbar range of motion, and palpable muscle spasms at the L4, L5, and S1 spinous processes. (AMA Guides, Table 15-3, DRE Category II, p. 384) (Joint Ex. M1, pp. 80, 84, 90.)

He assigned, by analogy, 5% WPI for each knee, supported by diagnosed bilateral chondromalacia patella, medial patellar tenderness, and positive for pain during the quadriceps compression test. (AMA Guides, Table 17-33, p. 546.) (*Id.* at p. 83-84, 89-90.) However, in his supplemental report dated August 22, 2023, he increased it to 15% WPI based on impacts on applicant's ADLs including avoiding prolonged walking, jumping, running, stair climbing, and sitting. (AMA Guides, Table 13-15, Class 2, p. 336) (Joint Ex. I1, p. 2.)

AME Dr. Schmidt assigned 0% WPI for the left shoulder based on a full range of motion, noting it caused no significant functional consequences or limitations in common ADLs, but 4% WPI for the right shoulder after conversion based on restricted range of motion (forward flexion 160°, abduction 160°, external rotation 30°, internal rotation 60°). (AMA Guides, Tables 16-40, p. 476; Table 16-43, p. 477; Table 16-46, p. 479.) (Joint Ex. M1, pp. 88, 90.) Given significant right shoulder weakness, deltoid atrophy, active numbness in the right deltoid, and a positive empty can sign, he assigned 15% WPI for the right shoulder. (AMA Guides, Table 16-35, p. 510.) (*Id.* at p. 90.) In addition, in his supplemental report dated June 26, 2023, he assessed 6% WPI for each shoulder, based on 10% upper extremity impairment attributable to resection arthroplasty of both shoulders. (AMA Guides, Table 16-27, p. 506.) (Joint Ex. J1, p. 5.)

He assigned 23% WPI to each hand for the carpal tunnel syndrome, confirmed via neurodiagnostic studies and positive bilateral Phalen and Tinel tests, clarified in his supplemental report dated December 26, 2023, based on a grade 3 classification (26-60% sensory deficit) and 39% UE impairment for the median nerve. (AMA Guides, Table 16-10, Grade 3, p. 482; Table 16-15, p. 492.) (Joint Ex. M1, 86, 89-90; Joint Ex. H1, p. 2.) He noted applicant's affected ADLs such as altered sleep patterns, difficulty entering and exiting vehicles, and diminished sexual function. (Joint Ex. M1, pp. 80-81.)

AME Dr. Schmidt recommended adding the impairments for the knees and lumbar spine, the neck and shoulders, and the hands and shoulders, explicitly referencing *Athens Administrators v. Workers' Comp. Appeals Bd.* (*Kite*) (2013) 78 Cal.Comp.Cases 213 (writ denied) (*Kite*) and regional syndrome methodology combining these values while accounting for clinical interactions like neck-shoulder and hand-shoulder syndromes. (*Id.* at pp. 89-90.)

Regarding apportionment, AME Dr. Schmidt stated that, with respect to the lumbar spine, given that applicant has had a prior history of motor vehicle accidents, both industrial and nonindustrial, it would be impossible to parcel them out without speculation. (*Id.* at p. 90.) In AME Dr. Schmidt's supplemental report dated June 3, 2022, he was unable to apportion between the previously resolved February 22, 2010 injury and the unresolved February 18, 1991 to November 20, 2018 and deemed them both interdependently intertwined. (Joint Ex. L1, p. 2.)

Given AME Dr. Schmidt's death, Dr. Nissanoff issued his supplemental medical-legal report dated November 18, 2025, recording applicant's reports of worsening subjective symptoms, including hands falling asleep during short drives, tingling, swelling, and nighttime awakening two to three times per night. Applicant reported evening neck pain requiring cracking and rolling for relief, which affected his ability to dress needing to use elastic button aids. He described an inability to stand or sit for prolonged periods due to low back pain, noting walking limitations of 10 minutes on good days and persistent pain following overexertion. He additionally noted bilateral knee pain during car and plane rides requiring him to stand and stretch, difficulty using the toilet or shower, and he described a cascading interconnectivity of symptoms where hand pain causes guarding that amplifies shoulder and neck pain, and knee pain causes leaning that exacerbates hip and back pain (App. Ex. 2, p. 3.) He reported functional limitations in ADLs, including switching hands to brush his teeth, substituting lever handles for round doorknobs,

restricting typing to five minutes, holding mugs with two hands, and holding the rail while climbing stairs. (*Id.* at p. 4.)

Dr. Nissanoff assigned the following WPI and resulting permanent disability ratings for each body part: 13% WPI for the cervical spine (27% permanent disability), 8% WPI for the lumbar spine (18% permanent disability), 23% WPI each for the left and right carpal tunnels (42% permanent disability each), 18% WPI for the right shoulder (37% permanent disability), 16% WPI for the left shoulder (37% permanent disability), and 5% WPI each for the left and right knees (13% permanent disability each). Using a standard Combined Values Chart (CVC) calculation before apportionment, these individual impairments combine to a 91% total permanent disability. (*Id.* at p. 5.)

However, Dr. Nissanoff also proposed an alternative approach to maximize the final rating. He argued that applicant's overlapping ailments have a cascading, synergistic impact on his ADLs, which justifies grouping and adding the impairments rather than strictly combining them. Under this method, he grouped the cervical spine, both carpal tunnels, and the right shoulder to calculate 100% permanent disability. He then grouped the lumbar spine and both knees for a 44% permanent disability. Combining these two grouped totals yielded a final 100% permanent disability. Finally, Dr. Nissanoff argued against nonindustrial apportionment, noting that earlier treatments had either failed or exacerbated applicant's conditions. (*Id.* at p. 6.)

In his report dated February 7, 2018, PQME Dr. Lee, after evaluating applicant in the field of psychiatry, diagnosed him with an Anxiety Disorder Not Otherwise Specified. (Joint Ex. G1, p. 70.) PQME Dr. Lee linked the psychiatric symptoms to applicant's February 22, 2010 industrial right shoulder injury with subsequent January 25, 2011 surgical complications. Applicant experienced significant blood loss and a cardiac arrhythmia requiring emergency cardioversion following his shoulder surgery, which precipitated the industrial psychiatric difficulties. (*Id.* at pp. 72-73.)

Applicant reported diminished sexual interest and sleep disturbances, which he explicitly attributed to orthopedic pain rather than depression. (*Id.* at p. 70.) Applicant denied current depressive symptoms and reported only mild anxiety regarding the potential recurrence of his cardiac issues. (*Id.* at p. 74.) Psychological testing corroborated these subjective reports, with applicant scoring a two on the Beck Depression Inventory-Second Edition and a four on the Beck

Anxiety Inventory, indicating minimal anxiety. He recorded a three on the Epworth Sleepiness Scale, demonstrating no excessive daytime sleepiness. (*Id.* at p. 70.)

PQME Dr. Lee documented mild ongoing impairment in applicant's adaptability to stress based on examination findings and ADLs. He had mildly anxious mood and affect, alongside a mild intensification of psychological distress when he experienced somatic cardiopulmonary symptoms. He had an objective preoccupation with pain, while psychological testing yielded anxiety and somatic patterns consistent with a pain disorder. (*Id.* at p. 74.)

PQME Dr. Lee assessed Global Assessment of Functioning (GAF) score of 68 (3% WPI) reflecting mild symptoms and mild difficulty in occupational or social functioning aligning with applicant's return to full-duty work without specific psychiatric restrictions. (*Ibid*.) He apportioned 95% to the February 22, 2010 injury and 5% to nonindustrial factors. (*Id.* at p. 75.)

In his subsequent report dated January 4, 2021, PQME Dr. Lee reevaluated applicant and determined that his psychiatric condition had deteriorated. (Joint Ex. E1, p. 16.) Subjectively, applicant reported worsening anxiety regarding his physical safety, fearing he could no longer defend himself against inmates due to deteriorating orthopedic conditions in his back, neck, and extremities. (*Id.* at pp. 14.) Applicant also reported new depressive symptoms, decreased energy, and sleep deprivation, which he attributed to both worsening physical pain and perceived unfair treatment from a new supervisor who denied him a promotion and retaliated following his transition to a new job in May 2019. (*Id.* at p. 15.) PQME Dr. Lee documented new objective clinical findings, noting a mildly depressed, constricted, and anxious mood and affect, alongside a thought process preoccupied with pain and workplace grievances. (*Id.* at p. 18.) Psychological testing, specifically the Minnesota Multiphasic Personality Inventory-2, revealed elevated clinical scales one, three, and four, confirming ongoing anxiety and somatic difficulties consistent with a pain disorder, alongside validity scales indicating an underreporting of psychiatric symptomatology. (*Id.* at p. 19.) Addressing compensability, AME Dr. Lee concluded that applicant's psychiatric worsening remained predominantly industrial, driven by actual events of employment that necessitated new mental health treatment. (*Id.*at p. 24.)

In his October 12, 2021 reevaluation report, PQME Dr. Lee apportioned causation as follows: 35% to aggravation by his new supervisor, 25% to the February 18, 1991 to November 20, 2018 injury, 10% to the inherent dangers of working with inmates, 10% to

workers' compensation treatment denials, and 20% to the February 22, 2010 injury. (Joint Ex. C1, p. 8.)

In his April 11, 2022 report, applicant described an anxious and depressed mood, together with heightened psychological distress triggered by reminders of his prior atrial fibrillation surgical complication. On mental status examination, PQME Dr. Lee observed a depressed, constricted, and anxious mood and affect. He found mild overall psychiatric impairment, with specific deficits in adapting to stress, preoccupation with physical pain, and perseveration regarding workplace mistreatment and workers' compensation treatment denials. He assigned a GAF score of 65, corresponding to 8% WPI. (Joint Ex. B1, p. 5.)

He apportioned 33% of the psychiatric permanent disability to the February 22, 2010 injury and January 25, 2011 cardiac complications, 2% to nonindustrial childhood sexual abuse, and 65% to the February 18, 1991 to November 20, 2018 injury. He further delineated this 65% industrial causation into 30% for supervisor mistreatment, 20% for the continuous trauma orthopedic injury, 7.5% for the hazards of working with inmates, and 7.5% for workers' compensation treatment denials. (*Id.* at p. 6.) Finally, he recommended adding rather than combining the psychiatric and orthopedic impairments pursuant to *Kite*, citing a known synergistic effect between the conditions corroborated by somatic findings on psychological testing. (*Id.* at pp. 6-7.)

In his report dated September 14, 2020, AME Dr. Woolf, after evaluating applicant in the field of internal medicine, reported that he developed acid reflux in 2011, characterized by heartburn and epigastric pain, alongside umbilical pain and bulging that began in 2007. (Def. Ex. W, pp. 5, 9.) AME Dr. Woolf documented subjective complaints including mild nausea, dysphagia, epigastric pain occurring twice weekly, and nocturnal heartburn resulting in sleep disruption. Applicant noted umbilical discomfort exacerbated by heavy lifting. (*Id.* at pp. 5-6.) In his follow-up evaluation dated July 7, 2021, after an initial upper endoscopy on May 5, 2021 revealed a superficial duodenal ulcer and moderate duodenitis, applicant ceased ibuprofen use and maintained daily omeprazole therapy. (Joint Ex. R1, pp. 4-5.) Applicant subsequently reported the resolution of vomiting and dysphagia, although he continued to experience weekly epigastric pain and nocturnal heartburn. (*Id.* at p. 5.)

Physical examinations conducted by AME Dr. Woolf consistently revealed an obese male with a body mass index of 32.2. (*Id.* at p. 6.) He palpated a soft abdomen with tenderness in the epigastrium and at the umbilicus. (*Id.* at pp. 4, 6.) He initially identified a 2 cm reducible inguinal

hernia and left groin tenderness during the September 14, 2020 evaluation. (Def. Ex. W, p. 7.) Subsequent evaluations dated July 7, 2021 and May 28, 2022, documented a 2 cm reducible umbilical hernia without abdominal distension. (Joint Ex. R1, p. 4; Joint Ex. Q1, p. 5.) An in-office breath test returned negative results for an active Helicobacter pylori infection. (Joint Ex. R1, p. 4.) A repeat upper endoscopy performed by AME Dr. Woolf on July 7, 2021, demonstrated mild gastric inflammation characterized by erythema in the gastric antrum, normal esophageal mucosa, and a healed duodenal ulcer with normal tissue in the second portion of the duodenum. (*Id.* at p. 8.) Biopsies obtained during this procedure confirmed the absence of Helicobacter pylori and Celiac Disease. (*Id.* at p. 6.)

In his report dated September 14, 2020, he diagnosed applicant with industrial acid reflux, an industrial umbilical hernia, and an industrial left inguinal strain or hernia. He concluded these conditions resulted from cumulative trauma rather than compensable consequences and therefore found them industrial. (Def. Ex. W, pp. 11-12.) He initially assessed 9% whole person impairment (WPI) for the upper digestive tract. (AMA Guides, Table 6-3, Class 1, p. 121.) After diagnosing and treating a duodenal ulcer, he issued a supplemental report dated May 28, 2022, increasing the impairment to 12% WPI without apportionment. (AMA Guides, Table 6-3, Class 2, p. 121.) He based the higher rating on applicant's daily use of omeprazole to control symptoms and placed him at the lower end of Class 2 because he had not experienced weight loss. (Joint Ex. Q1, p. 5.)

In his October 23, 2023 and May 9, 2024 evaluations, Dr. Ruder evaluated applicant's claims of industrial hearing loss and bilateral tinnitus. He reported that, for approximately six to seven years, he had experienced diminished hearing and intermittent ringing in both ears, which he attributed to occupational noise exposure from sirens, firearms used on the firing range, and other loud workplace environments. (Joint Ex. V1, p. 1; Joint Ex. Z1, p. 1.) In the October 23, 2023 report, applicant noted subjective difficulties understanding conversation in background noise, hearing over the telephone, and straining during verbal exchanges. He rated the loudness of his tinnitus at 7 out of 10, while scoring 9 out of 110 on the Tinnitus Reaction Questionnaire, indicating mild life impact without sleep disruption or concentration impairment. (Joint Ex. V1, p. 2.) He denied any family history of hearing loss, head trauma, recent ear infections, diabetes, dizziness, or exposure to ototoxic medications. (*Id.* at p. 1.)

In his May 9, 2024 report, Dr. Ruder documented a physical examination of applicant's head, neck, face, and ears that revealed normal external ear structures, intact tympanic membranes

with normal mobility, midline Weber testing, and a leftward nasal septal deviation obstructing 20% of the airway. (Joint Ex. Z1, p. 2.)

In his November 29, 2023 report, Dr. Ruder recorded reliable audiometric testing with speech reception thresholds of 25 dB and 100% speech discrimination scores bilaterally. Pure-tone audiometry demonstrated right-ear thresholds of 20 dB at 250, 500, 1000, and 2000 Hz; 30 dB at 3000 Hz; 40 dB at 4000 Hz; 45 dB at 6000 Hz; and 55 dB at 8000 Hz. The left ear demonstrated thresholds of 25 dB at 250 and 500 Hz; 20 dB at 1000 Hz; 25 dB at 2000 Hz; 30 dB at 3000 Hz; 35 dB at 4000 Hz; 50 dB at 6000 Hz; and 55 dB at 8000 Hz. Tympanometry demonstrated Type A curves with normal middle-ear pressures bilaterally, confirming mild-to-moderate high-frequency sensorineural hearing loss. (Joint Ex. W1, p. 2.)

In his report dated January 10, 2024, Dr. Ruder opined that applicant sustained occupational noise-induced hearing loss and bilateral tinnitus with reasonable medical probability. (Joint Ex. X1, pp. 1-2.) In his May 9, 2024 report, Dr. Ruder attributed the injury mechanism to repeated excessive noise exposures from sirens, firing ranges, and loud environments during his service as a correctional officer and parole officer from 1991 to 2019. (Joint Ex. Z1, pp. 1-2.) In his reports dated January 10, 2024 and May 9, 2024, Dr. Ruder emphasized that applicant's high-frequency hearing loss exceeded expected age-related thresholds and exhibited classical characteristics of occupational noise exposure. (Joint X1, p. 1; Joint Ex. Z1, p. 4.) In his report dated May 9, 2024, Dr. Ruder apportioned 100% to both conditions. (*Id.* at p. 5).

Dr. Ruder assessed 0% WPI for monaural impairment for both ears (AMA Guides, Table 11-1, p. 257), and 0% WPI for binaural hearing loss (AMA Guides, Table 11-2, pp. 248-249.) (*Id.* at p. 4.) This totals 0% WPI for hearing loss because the sum of the thresholds at 500, 1000, 2000, and 3000 Hz remained under 100 dB in each ear (AMA Guides, Table 11-3, p. 250.) He assigned 1% WPI for applicant's persistent tinnitus, noting that the ringing was absent during audiometric testing, although he did not identify the specific AMA Guides methodology supporting that impairment rating. (*Id.* at p. 5.) Additionally, he rated emotional impairment due to frustration associated with communication at 2% WPI. (AMA Guides, Table 13-8, Class 1, p. 325) (*Id.* at p. 6.)

On April 29, 2026, the WCJ issued her Amended F&A, awarding applicant 100% permanent disability without apportionment and admitting Dr. Nissanoff's supplemental report.

In her Report, the WCJ stated the following:

> [B]efore the case was submitted at trial the *Vigil* case was issued changing the standards for using addition rather than combined values when assessing permanent disability. Unfortunately, it was impossible to update Dr. Schmidt's opinion under the standards outlined in *Vigil* because Dr. Schmidt had died.
>
> Whether or not the permanent impairment should be added or combined was an issue that had been long standing in this matter. The *Vigil* case was issued on 06/10/24 *after* trial on this case had already begun. When the *Vigil* decision was issued, both parties knew or should have known that a supplemental medical opinion on this issue would be needed. The death of AME Schmidt M.D. did not render the issue moot.
>
> Defendant did not offer any evidence that they attempted to augment the record after the findings in the *Vigil* case. With Dr. Schmidt being deceased, applicant turned to the primary treating physician Dr. Jonathan Nissanoff to address the addition of permanent disability under *Vigil*.
>
> Defendant objected to the admissibility of Dr. Nissanoff's report, and the parties were asked to provide post-trial briefs on the issue. Defendant contended *solely* that the Nissanoff report should not be admitted because it was procured after the close of discovery at the mandatory settlement conference (MSC) on 10/10/2023. Defendant did not claim prejudice and did not seek leave to obtain additional discovery. Defendant simply did not want the report to be admitted.
>
> The court can reopen discovery when good cause is shown. A change in the law on the issues before the court, constitutes good cause to reopen discovery so that the record can be amended to comply with the new law. (*Fitzpatrick v. Department of Corrections & Rehabilitation*, 2020 Cal. Wrk. Comp. P.D. LEXIS 444.)
>
> Therefore, the admission of the report from Dr. Nissanoff was for good cause on issues that had been long standing on this case and due to both a change in the law and the death of the existing medical expert on the case.

(Report, pp. 6-7.)

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

DISCUSSION

I.

In order to constitute an industrial psychological injury, an employee must have sustained a compensable mental disorder, either directly or as a compensable consequence, "which cause[d] disability or need for medical treatment." (Lab. Code, § 3208.3(a).) Disability is evidence that there is either compensable "temporary disability" or "permanent disability." (*State Comp. Ins.*

Fund v. Workers' Comp. Appeals Bd. (Rodarte) (2004) 119 Cal.App.4th 998, 1005-1006 [69 Cal.Comp.Cases 579].)

To establish that a psychiatric injury is compensable, an employee must show by a preponderance of the evidence that actual events of employment predominantly caused the injury. (Lab. Code § 3208.3(b)(1).)

The Court of Appeal defined an "actual event of employment" as follows:

> First, the factor must be an "event"; i.e., it must be "something that takes place" American Heritage Dict. (4th ed. 2000) p. 616) in the employment relationship. Second, the event must be "of employment"; i.e., it must arise out of an employee's working relationship with his or her employer.

(*Pacific Gas & Electric Co. v. Workers' Comp. Appeals Bd. (Bryan)* (2004) 114 Cal.App.4th 1174, 1181 [69 Cal.Comp.Cases 21].)

However, section 3208.3(h) bars an employee from receiving compensation for stress and/or any physiological manifestations if a defendant meets its burden of proof that they substantially resulted from lawful, nondiscriminatory, good faith personnel actions. (Lab. Code, § 3208.3(h); *County of San Bernardino v. Workers' Comp. Appeals Bd. (McCoy)* (2012) 203 Cal.App.4th 1469 [77 Cal.Comp.Cases 219].) A "personnel action" is an action by or attributable to the employer, if done by one whom has authority over the injured employee, in managing its business. (*Larch v. Contra Costa County* (1998) 63 Cal.Comp.Cases 831, 833.) Personnel actions may include, but are not necessarily limited to, transfers, demotions, layoffs, performance evaluations, and disciplinary actions such as warnings, suspensions, and terminations of employment. (*Porter v. Tarzana Treatment Centers* [2013 Cal. Wrk. Comp. P.D. LEXIS 328, *7-8].)[3]

To navigate these statutory requirements, a physician determining compensability must analyze all the causal factors that contributed to the employee's need for psychological temporary disability and/or the need for medical treatment. In *Rolda v. Pitney Bowes, Inc.* (2001) 66 Cal.Comp.Cases 241, 245-246 (Appeals Board en banc), the Appeals Board addressed the factors that physicians must consider in opining on this causation under section 3208.3. Per *Rolda*,

[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.

a physician is required to list all factors causing psychological injury, address the percentage of causation that each factor contributes to the psychological injury, list all factors causing psychological permanent disability, and address the percentage of causation that each factor contributes to permanent disability. Once a physician issues a *Rolda* compliant report, the WCJ must then determine whether the alleged injury involved actual events of employment, and whether each event constituted a lawful, nondiscriminatory, good faith personnel action. Ultimately, if the psychological injury is predominantly caused (51% or more) by actual events of employment (or 35% or more in cases of injury caused by a violent act or exposure to a violent act), the injury is compensable, unless it is substantially caused by lawful, nondiscriminatory, good faith personnel actions, in which case it is barred.

Here, the evidentiary record regarding the compensability of applicant's alleged psychiatric injury remains insufficiently developed to permit a legally sound adjudication. The current medical reporting fundamentally fails to provide a legally tenable causation analysis pursuant to the strictures of section 3208.3(b)(1) and the multilevel framework articulated in *Rolda*.

Specifically, PQME Dr. Lee's quantitative causation opinion fails to adhere to the required analysis mandated by *Rolda*. First, attributing 35% of the psychiatric injury to perceived unfair treatment by a supervisor from a subsequent employer does not automatically defeat the present claim. Rather, if substantiated by the factual record, it necessitates amending the pleadings to conform to the evidentiary record. (See Cal. Code Regs., tit. 8, § 10517; *Perez v. Chicago Dogs* (2025) 90 Cal.Comp.Cases 830, 838 (Appeals Board en banc).) Second, his assignment of 10% causation to distress over workers' compensation medical treatment denials remains critically ambiguous. His reporting fails to delineate whether this distress is a compensable consequence of the underlying physical injury, stemming from the deprivation of necessary medical care, or merely a non-compensable psychiatric reaction to the litigation process itself. (See *Rodriguez v. Workers' Comp. Appeals Bd.* (1994) 21 Cal.App.4th 1747, 1757 [59 Cal.Comp.Cases 14].) Finally, assigning 20% of the causation to the February 22, 2010 injury creates a fundamental analytical contradiction. The prior determination of 3% WPI from that injury cannot be reconciled with the current assessment of 8% WPI, indicating that he improperly conflated the threshold issue of industrial causation with the apportionment of permanent disability. Collectively, these substantive deficiencies render the analysis legally defective under *Rolda*, as he failed to adequately isolate, define, and categorize the actual events of employment.

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

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

Defendant insists that by excising these legally impermissible or ambiguous causal factors from the medical analysis, the remaining industrial causation falls precipitously below the requisite predominant cause threshold, thereby warranting an adverse determination of non-compensability. We disagree with this proposed remedy. While PQME Dr. Lee's failure to apply the correct statutory framework renders his current causation analysis legally invalid, the defect lies in his medical-legal methodology rather than in an affirmative factual absence of industrial causation. Adopting defendant's position and issuing an adverse finding based on a flawed medical record would improperly penalize applicant for PQME Dr. Lee's legal error and analytical imprecision. Because the existing medical-legal evidence is legally insufficient to adjudicate the threshold issue

of industrial causation with the requisite certainty, the appropriate and constitutionally mandated remedy is further development of the record rather than an adverse finding.

II.

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 *Department of Corrections and Rehabilitation v. Workers' Comp. Appeals Bd*. (*Fitzpatrick*) (2018) 27 Cal.App.5th 607 [83 Cal.Comp.Cases 1680], the Court concluded 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*, the Appeals Board held that an injured employee could rebut the CVC under the PDRS and combine impairments upon establishing the impact of each impairment on ADLs. To do so, they 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.

(*Vigil, supra*, 89 Cal.Comp.Cases at p. 692, italics added.)

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 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 [36 Cal.Comp.Cases 93].)

Finally, section 5502(d)(3) provides that discovery closes at the time of the mandatory settlement conference (MSC), except that "[e]vidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference." (Lab. Code §5502(d)(3).)

Here, we discern no error in the WCJ's admission of Dr. Nissanoff's supplemental report after the closure of the MSC given the evolving legal standards set forth in *Vigil*. However, we conclude that there is good cause to reopen the evidentiary record more broadly regarding the calculation of permanent disability, particularly concerning the profound methodological shift between the standard application of the CVC and the addition of multiple impairments. The standard for rebutting the CVC demands explicit, meticulously detailed medical evidence demonstrating precisely how overlapping impairments synergistically amplify applicant's limitations in ADLs. The unfortunate passing of AME Dr. Schmidt created an evidentiary void, prompting the admission of a post-discovery supplemental medical-legal report from Dr. Nissanoff, dated November 18, 2025. Although the WCJ properly admitted this late reporting to address the intervening change in decisional law, fundamental principles of due process and

evidentiary fairness require reopening the evidentiary record rather than summarily closing it. While the WCJ emphasized that defendant failed to proffer its own supplemental evidence or formally seek leave to augment the record following *Vigil*, this procedural posture does not extinguish their due process rights. Defendant properly and timely advanced a valid objection to the admissibility of Dr. Nissanoff's report pursuant to section 5502(d)(3). By preserving an evidentiary objection to post-discovery reporting, a party does not waive its fundamental right to rebut that evidence if the trier of fact admits it over their objection. AME Dr. Schmidt's earlier reporting failed to adequately delineate the overlapping functional effects on ADLs necessary to justify combining the respective impairments. Therefore, once the WCJ determined that good cause existed to admit applicant's late medical evidence, principles of equity required reopening the record symmetrically. To ensure a constitutionally sound and medically accurate determination of permanent disability, defendant must have a full and fair opportunity to rebut Dr. Nissanoff's newly admitted assessment through supplemental medical reporting, comprehensive deposition testimony, or both.

III.

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

When analyzing prior injuries under section 4664, an employer's liability is strictly limited to the percentage of permanent disability directly caused by the subsequent industrial injury. While section 4664(b) establishes a conclusive presumption that a previously awarded permanent disability continues to exist, an employer seeking apportionment must satisfy a two-pronged evidentiary burden. As articulated in *Kopping*, *supra*, 142 Cal.App.4th 1099, an employer must prove both the existence of a prior permanent disability award and a functional overlap between the prior and subsequent disabilities. Crucially, it cannot establish overlap by the mere identity of the injured body part. Rather, it necessitates a comparative analysis of the specific factors of disability resulting from both injuries. (*Guedea v. Foley Family Wines, Inc.* [2024 Cal. Wrk. Comp. P.D. LEXIS 164, *20].)

Furthermore, overlap is demonstrated when the subsequent impairment represents a straightforward progression of the initial impairment, rated using the exact same chart or table

within the AMA *Guides*. Conversely, when not rating disabilities using a strict progression within the same chart, such as when an evaluating physician rates by analogy or utilizes disparate rating methodologies for the same body part, overlap becomes a factual inquiry. In these instances, the medical evidence must affirmatively establish that the impacts on ADLs from the current disability overlap with the impacts on ADLs measured in the prior disability, within the same body region. (*Canto Shadoan v. City of San Diego* [2025 Cal. Wrk. Comp. P.D. LEXIS 435, *16].)

Here, the current evidentiary record demands substantial development to resolve the complex issue of apportionment to prior permanent disability. The factual record establishes that applicant received a stipulated award of 42% permanent disability on February 6, 2019, encompassing specific impairments to the right shoulder, the upper gastrointestinal tract, and the psyche. This prior award relied expressly on the original medical reporting that established the WPIs, specifically the reports of AME Dr. Schmidt dated May 1, 2017, AME Dr. Caren dated August 14, 2013, PQME Dr. Lee dated February 7, 2018, and AME Dr. Fink dated May 8, 2013, and October 16, 2017. Notably, defendant failed to submit AME Dr. Fink's May 8, 2013 and October 16, 2017 reports into evidence for our review.

A rigorous comparison between these prior and current medical reports strongly indicates a significant functional overlap between the past disabilities and the present impairments. For illustration, the medical-legal evaluators assessed the upper gastrointestinal impairment in the present cumulative injury case using the same table in the AMA Guides that formulated the prior award. Specifically, AME Dr. Woolf utilized Table 6-3 of the AMA Guides to evaluate the upper digestive tract, directly paralleling the baseline AME Dr. Caren established in the prior claim. Similarly, while PQME Dr. Lee assessed a GAF score of 65 (8% WPI) in his April 11, 2022 report, this assessment creates an unresolved apportionment conflict when compared to his February 7, 2018 report, which found a GAF score of 68 (3% WPI). Because permanent disability apportionment must be based on causation pursuant to section 4663, his current reporting improperly fragments causation among the February 22, 2010 injury, the February 18, 1991 to November 20, 2018 injury, and nonindustrial factors without providing the granular ADL analysis necessary to legally untangle the overlap with the conclusively presumed prior permanent disability under section 4664.

Furthermore, AME Dr. Schmidt's May 1, 2017 report assessed 6% WPI for ROM deficit pursuant to Table 16-3 of the AMA Guides. The current medical reports establishing the

right shoulder's WPI evaluated this identical joint, utilizing diagnostic metrics that inherently intertwine with the prior assessment parameters. These current metrics include AME Dr. Schmidt's assigning 15% WPI for weakness and 6% WPI for a resection arthroplasty, alongside Dr. Nissanoff's supplemental report assigning 18% WPI.

Despite these pronounced indications of overlapping disability, the existing medical record lacks a precise comparison of the specific disability factors and their correlative impacts on applicant's ADLs within the identically affected body regions. Because this meticulous factual inquiry remains legally indispensable to measure functional overlap accurately and to execute the apportionment of permanent disability under section 4664 lawfully, the current medical record proves thoroughly inadequate and necessitates further evidentiary development.

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

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the April 29, 2026 Amended Findings and Award is **RESCINDED** with the following **SUBSTITUTED** therefor:

FINDINGS OF FACT

1. Gabriel Rogers, while employed as a parole agent, occupation group number 490, at Pomona, California by the California Department of Corrections & Rehabilitation during the period February 18, 1991 to November 20, 2018, sustained injury arising out of and in the course of employment to the cervical spine, lumbar spine, bilateral carpal tunnel, bilateral shoulders, bilateral knees, upper GI and ear/hearing. The issue of injury to psyche is deferred.

2. At the time of injury, the employer was legally uninsured and administered by State Compensation Insurance Fund.

3. Applicant's injury caused total temporary disability, payable at the rate of $ 1,215.27 per week beginning November 21, 2018 to and including June 17, 2021 subject to the Labor Code section 4656 statutory limitations of entitlement to temporary disability, less credit to defendant for all sums including temporary disability and IDL previously paid on account thereof, and for days worked and wages earned. To be adjusted by the parties with jurisdiction

reserved in the event of a dispute.

4. The issue of permanent disability is deferred.

5. The issue of apportionment is deferred.

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

7. Employment Development Department is entitled to reimbursement of its lien claim to the extent that it provided benefits concurrently with the award of temporary disability/permanent disability.

8. The issue of attorney fees is deferred.

AWARD

AWARD IS MADE in favor of Gabriel Rogers against California Department of Corrections & Rehabilitation, legally uninsured, administered by State Compensation Insurance Fund, as follows:

1. Temporary disability in accordance with Finding of Fact 3 above.
2. Further medical treatment in accordance with Findings of Fact 6 above.

ORDER

IT IS ORDERED that Applicant's Exhibit 2, the November 18, 2025 report from Jonathan Nissanoff, M.D., is admitted into evidence.

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG L. SNELLINGS, COMMISSIONER

I CONCUR,

/s/ JOSÉ H. RAZO, COMMISSIONER

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

October 22, 2026

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

GABRIEL ROGERS
MALLERY & STERN
STATE COMPENSATION INSURANCE FUND

DLP/md

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