WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

JUAN ALEGRIA, *Applicant*

vs.

J. F. ELECTRICAL, INC.; CALIFORNIA INSURANCE GUARANTEE ASSOCIATION, by its servicing facility INTERCARE HOLDINGS INSURANCE SERVICES, INC., on behalf of CASTLEPOINT NATIONAL INSURANCE COMPANY, formerly known as TOWER INSURANCE COMPANY OF NEW YORK, in liquidation, *Defendants*

Adjudication Number: ADJ8760173
Santa Ana District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration to allow us time to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.[1]

Defendant seeks reconsideration of the Findings and Order and Award (FA&O) issued on May 24, 2022, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant, while employed on December 27, 2012, as an electrician, sustained an industrial injury to his back, left shoulder, right knee, left ankle, psyche, urologic system, internal system, and in the form of sexual dysfunction, resulting in 100% permanent disability without apportionment.

Defendant contends that the WCJ erred in awarding 100% permanent disability without apportionment, arguing that the award incorrectly assigns liability for permanent disability not caused by the industrial injury and fails to apply the non-industrial apportionment established by the Qualified Medical Evaluators (QMEs). Specifically, defendant argues that the reporting of applicant's vocational expert, Ray Largo, M.A., does not constitute substantial evidence because he disregarded the medical apportionment determinations provided by the QMEs. Furthermore, defendant asserts that the WCJ erred by admitting and relying on the medical reporting of Mohammed Zain Vally, M.D., contending Dr. Vally's reports are inadmissible and do

[1] Commissioner Sweeney was on the panel that issued the order granting reconsideration. Commissioner Sweeney no longer serves on the Appeals Board. A new panel member has been appointed in her place.

not constitute substantial medical evidence because he failed to report to the primary treating physician as required for secondary treating physicians, failed to conduct a physical examination, and did not frame his opinions in terms of reasonable medical probability.

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

We have considered the allegations in defendant's Petition and applicant's 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 affirm the FA&O.

FACTS

Pursuant to the stipulation of the parties, applicant, while employed as an electrician on December 27, 2012, sustained an industrial injury to his back, left shoulder, right knee, left ankle, psyche, urologic system, internal system, and in the form of sexual dysfunction. (Minutes of Hearing and Summary of Evidence (MOH/SOE), 06/23/2021, 2:5-8.)

Parties jointly submitted into evidence the QME reports of Michael Luciano, M.D. (Joint Exs. 1-4), Ernest Agatstein, M.D. (Joint Exs. 4-6), Can Tang, M.D. (Joint Exs. 7-11), and James Lineback, M.D. (Joint Exs. 12-16). Applicant submitted into evidence treating physician reports from David Friedman, M.D., Ph.D. (App. Exs. 1-7, 25-28), Zain Vally, M.D. (App. Exs. 9-10), Edward Thomas Chappell, M.D. (App. Exs. 18-19), and Fabian Proano, M.D. (App. Exs. 16-17, 20-24), as well as the vocational expert reports of Aida Perez, M.A. (App. Ex. 10), and Mr. Largo (App. Exs. 11-12). Defendant submitted into evidence the vocational expert reports of Christopher Meyers, M.R.C. (Def. Exs. A-B) as well as sub rosa videos of applicant (Def. Exs. H-J).

Pursuant to QME Dr. Lineback's report dated October 6, 2016, on December 27, 2012, while working as an electrician, applicant fell approximately 12 to 15 feet from an extension ladder that slipped from beneath him. He landed on his feet and immediately felt a break in his left foot. After transport to Torrance Memorial Hospital, he underwent X-rays revealing a heel bone fracture. (Joint Ex. 16, p. 2.)

Applicant testified in pertinent part that he had undergone approximately ten surgeries on his left foot and ankle area between December 2012 and September 2015. (MOH/SOE,

06/23/2021, 6:24-25.) He currently receives treatment from pain specialist Dr. Proano for complex pain and consults with Dr. Friedman to discuss his physical and psychological distress. (MOH/SOE, 06/23/2021, 6:18-20.) Applicant suffered a heart attack in April 2015, resulting in the surgical implantation of a stent by his cardiologist, Basil Younes, M.D. (MOH/SOE, 06/23/2021, 7:1-3.) He attributed this cardiac event to severe physical pain and a persistent fear of leg amputation. (MOH/SOE, 06/23/2021, 7:6-9.) In addition to his physical injuries, applicant developed claustrophobia during a surgical procedure, which now causes anxiety in elevators and windowless rooms. (MOH/SOE, 09/15/2021, 3:24-25 to 4:1-5.) He relies heavily on medications that induce drowsiness and brain fog, hindering his concentration and decision-making abilities. (MOH/SOE, 09/15/2021, 3:22-23.) Although QME Dr. Tang concluded that applicant's subjective pain complaints and ratings were not credible, he disputed this assessment, maintaining that he answered all the questions honestly despite feeling anger over delayed prescription medications during the psychiatric evaluation. (MOH/SOE, 03/03/2022, 4:7-15.)

Regarding his activities of daily living (ADLs), he reported persistent pain in his low back, left shoulder, right knee, and left foot, which restricts his physical endurance. (MOH/SOE, 06/23/2021, 9:14-20.) He wears a medical boot constantly, except when sleeping, and experiences instability when walking without it. (MOH/SOE, 06/23/2021, 7:21-24.) Sleep disruptions are frequent, averaging only five hours of poor-quality sleep per night, interrupted by physical pain and recurring nightmares regarding amputation and death. (MOH/SOE, 06/23/2021, 8:15-20.) When his foot slips off his support pillow at night, he experiences a sudden burning sensation that awakens him. (MOH/SOE, 06/23/2021, 8:21-25 to 9:1-2.) During the day, his morning routine consists of minor household chores and walking his dog for 30 to 45 minutes. (MOH/SOE, 06/23/2021, 7:13-15, 8:2-3.) Despite increasing his pain levels, he continues to walk daily upon the strict advice of his physicians to prevent another heart attack. (MOH/SOE, 06/23/2021, 9:4-6.) Following exertion, he must elevate his foot four to five times per day for extended periods to manage throbbing pain and inflammation. (MOH/SOE, 06/23/2021, 7:15-18.) He drives approximately 10 miles daily to run errands and attend medical appointments, but his pain limits his driving tolerance to 20 minutes before requiring a break. (MOH/SOE, 09/15/2021, 2:19-23.)

Sub rosa video recorded on August 25, 2020, spanning 2 hours and 17 minutes, depicts applicant engaging in various ADLs, including walking his dog, driving a vehicle, and dining at a restaurant. (Def. Ex. H; MOH/SOE, 09/15/2021, 4:17-20, 5:19-23, 6:1-5, 8:5-6.) The footage

begins at 9:12 a.m., showing him wearing a knee-high boot on his left leg, standing outside his residence, and holding a dog leash. (MOH/SOE, 09/15/2021, 4:17-20.) At approximately 9:20 a.m., he walks his dog along the sidewalk, passing the leash between his left and right hands behind his back, meandering in response to the dog, and bending over to clean up after the animal. (MOH/SOE, 09/15/2021, 4:23-25 to 5:1-4.) After entering and exiting a building briefly, he opens the rear doors of his vehicle, leans into the back seat, and retrieves a large, filled white trash bag approximately the size of his torso, which he places into the trunk along with two additional items. (MOH/SOE, 09/15/2021, 5:9-17.) He then enters the driver's side and drives to multiple parking lots, eventually arriving at a restaurant with his wife. (MOH/SOE, 09/15/2021, 5:19-25 to 6:1-2, 12-13.) At 10:55 a.m., he sits outside looking at his mobile phone, drinking, and eating a hamburger and french fries before driving away. (MOH/SOE, 09/15/2021, 6:1-8; 8:1-2; MOH/SOE, 03/03/2022, 7:25 to 8:1-2.)

Testifying regarding the video, applicant confirmed his identity and stated that, despite his outward appearance, he experienced severe burning and puncturing pain in his foot throughout the recording. (MOH/SOE, 09/15/2021, 6:12-13, 7:12-13.) He clarified that he utilizes these rare outings to manage severe depression but must immediately elevate his foot upon returning home. (MOH/SOE, 09/15/2021, 7:7-9, 8:3-4.) While his foot swells after 30 minutes of walking, necessitating elevation, he delayed elevating his foot for 90 minutes after the recorded walk to attend the restaurant lunch. (MOH/SOE, 09/15/2021, 7:5-9.) He noted driving and sitting at the restaurant without elevation were both painful activities. (MOH/SOE, 09/15/2021, 8:7-8.) Furthermore, he acknowledged experiencing weight gain, which doctors warned hinders his physical recovery. (MOH/SOE, 09/15/2021, 7:19-25.)

Addressing his feasibility for vocational rehabilitation, applicant disagreed with Mr. Myers and QME Dr. Luciano regarding his capacity to return to the workforce. (MOH/SOE, 09/15/2021, 3:3-7; MOH/SOE, 03/03/2022, 3:18-21.) He further testified he was unaware that QME Dr. Luciano relied on the sub rosa video to conclude that he was capable of working within orthopedic restrictions and not entirely disabled. (MOH/SOE, 03/03/2022, 3:21-24.) He rejected the feasibility of working as a parking lot attendant, assembler, or dispatcher, stating that he must frequently elevate his leg, experiences unpredictable pain flare-ups, and has medication-induced cognitive deficits that prevent him from sustaining regular employment. (MOH/SOE, 09/15/2021, 3:7-14.) He indicated that he would need to leave work early three to four times per week due to

unbearable pain. (MOH/SOE, 09/15/2021, 3:9-11.) Ultimately, he stated he is incapable of looking for work, feeling fundamentally changed by his constant pain, dependency on medication, and inability to concentrate. (MOH/SOE, 09/15/2021, 3:17-19.)

Michelle Alegria, applicant's wife, provided corroborating testimony regarding her observations of his physical limitations, ADLs, and vocational capacity. She testified that they married in August 2012, shortly before his work injury, and noted that his resulting disability causes severe mood swings and a loss of joy in their lives. (MOH/SOE, 03/03/2022, 5:24-25, 6:9-10, 7:18-19.) She actively observed his ongoing cognitive difficulties, which include troubles with concentration, long pauses during conversations, difficulty remembering words, and a failure to maintain eye contact. To assist him with his ADLs, she sent him daily text messages to remind him of certain tasks. (MOH/SOE, 03/03/2022, 6:1-5.)

Regarding his physical symptoms, she noted that he wears a medical boot most of the day, prompting her to wait until the evening to massage his left calf, left ankle, left heel, and right foot. (MOH/SOE, 03/03/2022, 6:6-9.) She indicated that his pain is constant but worsens as the day progresses, resulting in low energy and the need to take two or three naps daily. (MOH/SOE, 03/03/2022, 6:25 to 7:1.) She testified that he remains stoic and prefers to avoid drawing attention to himself, meaning he does not display physical distress on his face. However, she recognizes his pain levels by observing his pronounced limp, agitation, and tendency to shut down emotionally. (MOH/SOE, 03/03/2022, 6:12-16.) His chronic pain causes severe mood swings, turning a once happy person into someone who yells and is verbally abusive, though she clarified he has never threatened physical violence against her. (MOH/SOE, 03/03/2022, 8:23-25 to 9:1.)

Addressing the sub rosa video, she corroborated applicant's account, explaining that he avoided resting his foot at the restaurant to prevent drawing attention to himself and that the outing was a rare celebration. (MOH/SOE, 03/03/2022, 7:7-8, 7:7-12.) She confirmed that, upon returning home, he consistently adheres to a strict routine of elevating his foot on the couch. (MOH/SOE, 03/03/2022, 7:8-10, 7:11-13.) She expressed concern regarding his weight gain, estimating his current weight at 240 to 242 pounds, which she attributes to his depression and a shift to a sedentary lifestyle. (MOH/SOE, 03/03/2022, 7:4-6.) She attempts to manage his diet through food preparation and healthier options but acknowledges his motivation to lose weight fluctuates due to his depressive state. (MOH/SOE, 03/03/2022, 7:21-24, 8:2-5.) She further questioned whether weight reduction would alleviate the trauma in his heel. (MOH/SOE, 03/03/2022, 8:11-13.)

Finally, addressing his vocational capabilities, she stated that he has neither worked nor looked for employment since his injury. (MOH/SOE, 03/03/2022, 8:18-19.) Although aware that defendant believes he can work within certain orthopedic restrictions, she firmly disagrees, asserting that his pain, lack of concentration, constant need to rest his foot, and reliance on daily naps prevent him from maintaining a regular work schedule. (MOH/SOE, 03/03/2022, 7:13-18.)

In his medical report dated June 3, 2020, Dr. Vally, after evaluating applicant in pain management, diagnosed him with left foot pain, complex regional pain syndrome, hypertension, and a history of a myocardial infarction. During the physical examination on that date, Dr. Vally recorded objective findings including a blood pressure of 139/82, a pulse of 70, tenderness to palpation, and muscle spasms in the affected extremity. Additionally, he observed a decreased range of motion in the left ankle, significant minor edema, and notable hairlessness and color changes upon removal of applicant's brace, which Dr. Vally identified as clinical signs of complex regional pain syndrome. At that time, he noted applicant experienced constant left ankle pain rated at six out of ten. (App. Ex. 9, p. 1.)

In the subsequent evaluation report dated February 24, 2021, Dr. Vally maintained the same four diagnoses but deemed applicant permanently totally disabled. (App. Ex. 8, pp. 1-2.) Although Dr. Vally did not perform a physical examination due to COVID-19 restrictions, he noted that applicant's ankle pain fluctuated between six and eight out of ten and worsened with stepping, walking, climbing, and prolonged standing. Addressing work restrictions and vocational feasibility, Dr. Vally concluded that applicant is unable to return to work and cannot meaningfully participate in vocational rehabilitation. Dr. Vally attributed this complete loss of earning capacity to the physical limitations caused by the complex regional pain syndrome, the cardiovascular comorbid issues resulting from the work injury, and the severe cognitive side effects of the chronic narcotic medications required to manage applicant's pain. Dr. Vally specifically identified drowsiness, inability to focus, and difficulty working as significant side effects of the prescribed opioid regimen, which previously failed multiple weaning trials. (*Id.* at p. 1.) Consequently, given applicant's disability status, Dr. Vally canceled the pending functional capacity evaluation, stating that applicant is no longer a viable candidate for vocational rehabilitation. (*Id.* at p. 2.)

In his medical reports, Dr. Proano, after evaluating applicant in the field of pain management, diagnosed him on April 21, 2021 and May 20, 2021, with left lumbar radiculitis, L4-L5 radiculopathy and complex regional pain syndrome of the left lower extremity stemming from

a prior crush injury to his heel. (App. Ex. 17, pp. 1, 2; App. Ex. 16, p. 2.) In Dr. Proano's medical report dated June 17, 2021, he observed that applicant's MRI conducted on June 14, 2021 provided extensive objective evidence of multiple level disc degeneration, disc herniations at L3-S1, central stenosis at L3-L5, and foraminal stenosis at L4-L5 and L5-S1. (App. Ex. 24, p. 1.) During his physical examinations on May 20, 2021 and June 17, 2021, he repeatedly recorded objective findings including positive straight leg raise tests on the left side decreased sensation in the L4-L5 dermatomes and significant motor weakness affecting left knee extension and flexion, left great toe dorsiflexion, and foot plantar flexion. Additionally, he observed a diminished left patellar reflex and noted hypersensitivity and allodynia to light touch over the left lower extremity. (App. Ex. 16, p. 2; App. Ex. 24, p. 2.)

Addressing applicant's functional capacity, Dr. Proano outlined severe work restrictions and limitations indicating that the ongoing pain caused significant disruption in performing basic ADLs including standing, walking, sitting, climbing stairs, bending, lifting, transferring, driving, exercising, and sleeping. (App. Ex. 24, p. 1.) Applicant requires, based on the medical reports dated October 6, 2021 and November 4, 2021, a medical regimen utilizing opioid medications including oxycodone and gabapentin, with Celebrex as an anti-inflammatory medication. (App. Ex. 21, p. 1; App. Ex. 20, p. 1.) To manage the physical instability, Dr. Proano prescribed specific medical equipment including an Arizona ankle brace. (*Id.* at p. 2.) In addition, in his medical report dated August 17, 2021, he prescribed a compressive lumbar-sacral orthotic brace to maintain spinal stability and reduce inflammation. (App. Ex. 22, p. 2.)

In his medical reports dated March 17, 2021 and April 14, 2021, Dr. Chappell, after evaluating applicant in the field of neurology, diagnosed him with complex regional pain syndrome I of the left lower extremity. (App. Ex. 19, p. 1; App. Ex. 18, p. 5.) Dr. Chappell described the condition as chronic, highly refractory to conventional treatment modalities, and severely debilitating. (App. Ex. 19, p. 4; App. Ex. 18, p. 5.) Applicant experienced constant, sharp, and burning pain rated at an intensity of 8 out of 10, which originates in the left foot and ankle before spreading up through the entire left lower extremity and frequently disrupting his sleep pattern. (App. Ex. 19, pp. 2-3; App. Ex. 18, p. 3.)

Objective clinical findings across both evaluations consistently demonstrated classic presentation criteria for complex regional pain syndrome, including profound allodynia, altered sensation over the left lower extremity, localized swelling, skin discoloration, skin glossiness,

tapering fingertips, and severe stiffness throughout the ankle and foot joints (App. Ex. 19, p. 3; App. Ex. 18, p. 4). Observation of applicant's gait revealed a pronounced limp favoring the left side, accompanied by visible facial grimacing and audible moaning (*Id.* at p. 5). Severe guarding and intense allodynia prevented an accurate or meaningful sensory and motor examination of the left lower extremity, and he could not tolerate coordination testing at the left ankle joint. (*Id.* at pp. 4-5). Furthermore, he was unable to execute toe-walking or heel-walking maneuvers during testing due to the severity of his left foot pain (*Id.* at p. 4).

In his report dated April 14, 2021, Dr. Chappell deemed applicant permanent and stationary and assessed 15% whole person impairment (WPI) under Class 2, Table 13-15 of the AMA Guides to the Evaluation of Impairment (AMA Guides). Dr. Chappell restricted applicant from sustained weight bearing on the left lower extremity, as well as avoid prolonged walking or standing. (*Id.* at p. 6). With respect to apportionment, Dr. Chappell concluded that the WPI is entirely due to the December 27, 2012 injury. (*Id.* at p. 8).

In his report dated June 11, 2018, Dr. Friedman, after evaluating applicant in the field of psychiatry, diagnosed him with major depression, single episode, moderate to severe, non-psychotic, along with a pain disorder associated with both psychological factors and a general medical condition. (App. Ex. 7, p. 24.) Dr. Friedman assessed a Global Assessment of Functioning (GAF) score of 53, yielding 26% WPI in accordance with the AMA Guides and noted an Epworth Sleepiness Scale score of 18 out of 24. (*Id.* at pp. 24, 27.) Dr. Friedman concluded that the combined impairments in orthopedics, internal medicine, and psychiatry precluded applicant from returning to substantial gainful employment, creating a 100% loss of preinjury capacity for work. (*Id.* at p. 27.) Furthermore, Dr. Friedman apportioned 100% of the WPI to the December 27, 2012 injury. (*Id.* at p. 28.)

Dr. Friedman subsequently re-evaluated applicant on December 3, 2019, recording objective findings during a mental status examination that included applicant presenting in obvious discomfort, frequently changing positions, and ambulating slowly with his left foot in a boot. Dr. Friedman observed a moderately depressed and anxious mood accompanied by a somber affect and intermittent tearfulness. (App. Ex. 3, p. 16.) Diagnostic testing yielded a valid Test of Memory Malingering score of 50, a Beck Depression Inventory score of 23 indicating moderate depression, and a Beck Anxiety Inventory score of 36 indicating severe anxiety. (*Id.* at pp. 13-14). Following

these measurements, Dr. Friedman maintained the diagnoses of major depression and pain disorder, measuring a revised GAF score of 55, which yielded 23% WPI. (*Id.* at pp. 16-17.)

In assessing work restrictions and overall disability, Dr. Friedman reiterated that the combined impairments in orthopedics, internal medicine, and psychiatry preclude a return to substantial gainful employment, establishing a 100% loss of preinjury capacity for work. He noted that applicant, who receives Social Security disability benefits, has not returned to work since the December 27, 2012 injury. Finally, Dr. Friedman reaffirmed that the December 27, 2012 orthopedic injury caused the psychiatric condition, assigning 100% of the resulting WPI to that single event. (*Id.* at p. 20.)

In his report dated January 30, 2014, QME Dr. Luciano, after evaluating applicant, diagnosed him with left shoulder tendinitis, lumbosacral strain, right knee strain, and a left calcaneus fracture complicated by osteomyelitis. (*Id.* at p. 28.) QME Dr. Luciano documented objective measurement deficits, recording left shoulder flexion at 136° and noting limitations across multiple planes of motion. (*Id.* at p. 25.) Additional objective findings included paralumbar tenderness with muscle guarding, and right knee discomfort. (*Id.* at pp. 26-27.) Surgical bandaging prevented a complete examination of the left lower extremity. (*Id.* at pp. 28, 32.)

In his subsequent evaluation on September 24, 2015, QME Dr. Luciano maintained the diagnoses of left shoulder tendinitis, lumbosacral strain, right knee strain, and a left foot fracture with osteomyelitis. (Joint Ex. 3, p. 3.) He recorded objective complaints of left shoulder pain increasing with activity, back pain exacerbated by standing or sitting, and right knee pain increasing with weight bearing. He noted applicant utilized a crutch for ambulation, possessed very limited weight-bearing abilities, and required regular narcotic medication. (*Id.* at p. 4.)

In his next evaluation report dated August 5, 2016, QME Dr. Luciano diagnosed applicant with left shoulder tendinitis, lumbosacral strain, right knee strain, and a severely comminuted fracture of the left calcaneus complicated by chronic non-union and osteomyelitis. (Joint Ex. 2, pp. 2–3, 18.) Because of his injury, he underwent approximately ten surgical procedures to his left foot and ankle, including open reduction and internal fixation, hardware removal, multiple irrigations and debridements, bone biopsies, the placement and removal of an antibiotic cement spacer, a reverse sural flap reconstruction, and subsequent debulking of the left gastrocnemius muscle. (*Id.* at pp. 2-3, 6-8, 18.) He reported constant pain in his left foot alongside activity-induced pain in his left shoulder, low back, and right knee, mobility limitations requiring an ankle brace,

walking tolerance restricted to 15 to 20 minutes without other ambulatory assistance, and a reliance on regular narcotic medications, including Percocet and Opana, to manage his symptoms. (*Id.* at pp. 4-6.) Objective clinical findings and physical measurements revealed that, for the left shoulder, goniometric testing demonstrates restricted ROM with flexion at 150/136° and abduction at 150/124°, accompanied by generalized tenderness, decreased motor strength graded at 4+ out of 5 across all planes, and documented grip strength loss in the left upper extremity during Jamar testing. (*Id.* at pp. 11, 13-14.) An MRI of the left shoulder dated October 14, 2015 confirmed articular-sided partial tearing at the junction of the supraspinatus and infraspinatus tendons alongside degenerative changes of the acromioclavicular joint. (*Id.* at p. 8.) Examination of the lumbosacral spine revealed localized tenderness and prominent muscle guarding over the paralumbar region, while a lumbar spine MRI dated October 14, 2015 showed disc desiccation and broad-based protrusions measuring 1 to 3 mm. from L3-L4 to L5-S1, causing moderate-to-severe bilateral neural foraminal stenosis and central canal stenosis most pronounced at L4-L5. (*Id.* at pp. 3, 7-8, 15.) The right knee exhibited generalized tenderness over the medial and lateral joint lines, palpable crepitation, and muscle weakness with a 4+ motor strength grading of the right quadriceps musculature, which correlated with applicant's subjective complaints of his knee buckling during weight-bearing activities. (*Id.* at pp. 5, 16–18.) The left ankle and foot manifested profound pathology, characterized by distortion of normal anatomical integrity, extensive surgical scarring on the posterolateral aspect, and exquisite tenderness to palpation on all sides of the left calcaneus. Left ankle range of motion was severely restricted, showing an extension of only 4° against a normal 20°, flexion of 10° against a normal 40°, and a total loss of inversion and eversion capabilities. (*Id.* at p. 17.) Additionally, tape measurements revealed muscular atrophy, with the left calf circumference measuring 16 inches compared to 17 inches on the right, alongside reduced motor strength graded at 3 out of 5 for the tibialis anterior, gastrocnemius, and extensor hallucis longus muscles. (*Id.* at pp. 17-18.)

With respect to permanent disability, for the left shoulder, QME Dr. Luciano measured flexion of 136° for 3% upper extremity (UE) impairment, extension of 40° for 0% UE impairment (AMA Guides, Figure 16-40, p. 476), abduction of 124° for 3% UE impairment, adduction of 30° for 0% UE impairment, (AMA Guides, Figure 16-43, p. 477), internal rotation of 64° for 2% UE impairment, and external rotation of 72° for 0% UE impairment (AMA Guides, Figure 16-46, p. 479), yielding a total ROM impairment of 8% UE impairment. (*Id.* at pp. 23-24.) He calculated

an additional 7% UE impairment for muscle strength deficits based on Grade 4 motor strength across extension, flexion, abduction, adduction, internal rotation, and external rotation. (AMA Guides, Tables 16-11, 16-35, pp. 484, 510.) (*Id.* at p. 24.)

Utilizing *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc) (*Almaraz/Guzman II*), he combined the ROM and muscle strength impairments for 14% UE impairment, converting this to 8% WPI. (AMA Guides, Table 16-3, p. 439.) (*Id.* at pp. 24-25.)

For the lumbar spine, relying on objective clinical findings of paralumbar tenderness with muscle guarding and a lumbar spine MRI dated October 14, 2015 demonstrating multi-level disc protrusions and central canal stenosis, he placed applicant in DRE Category II, assessing 6% WPI. (AMA Guides, Table 15-3, p. 384.) (*Id.* at pp. 3, 7-8, 25.)

For the right knee, QME Dr. Luciano recorded a Grade 4+ motor strength of the right quadriceps, yielding 12% lower extremity (LE) impairment that converted to 5% WPI. (AMA Guides, Tables 17-3, 17-7, 17-8, p. 527, 531-532.) (*Id.* at p. 25.) He added 2% WPI for right knee crepitation, totalling 7% WPI. (AMA Guides, Table 17-31, p. 544.) (*Id.* at p. 26.)

For the left ankle and hindfoot, he recorded flexion of 10° for 15% LE impairment, extension of 4° for 7% LE impairment, eversion of 0° for 5% LE impairment, and inversion of 0° for 2% LE impairment, totaling 29% LE impairment or 12% WPI. (AMA Guides, Tables 17-3, 17-11, 17-12, 17-13, pp. 527, 537.) However, applying *Almaraz/Guzman II*, he utilized an alternate rating method because applicant walked with assistance, assigning a Class 3 station and gait disorder designation for 30% WPI for the left ankle. (AMA Guides, Table 13-15, p. 336.) QME Dr. Luciano combined 30% WPI for the left lower extremity with 7% WPI for the right lower extremity to reach 35% WPI for the bilateral lower extremities, and finally combined this with 8% WPI for the left shoulder and 6% WPI for the lumbar spine using the combined values chart to total 44% WPI. (AMA Guides, p. 604, p. 604-605.) (*Id.* at pp. 26-27.)

He established specific work restrictions precluding applicant from repetitive above-shoulder-level work for the left shoulder, as well as heavy lifting and repetitive bending for the lumbar spine. QME Dr. Luciano further restricted applicant from repetitive or prolonged kneeling, squatting, and stair climbing for the right knee, and from prolonged weight bearing or walking on uneven ground for the left foot and ankle. (*Id.* at p. 23.)

With respect to apportionment, QME Dr. Luciano addressed the left shoulder, lumbar spine, and right knee, basing his conclusions on "the nature and extent of the diagnosed condition on clinical examination and per diagnostic reports, and the nature of the mechanism of industrious exposure." Accordingly, QME Dr. Luciano apportioned for each of these three body parts 10% to non-industrial "activities associated with daily living" and 90% to the December 27, 2012 injury. (*Id.* at p. 28.) Applying this methodology to the left foot and ankle condition, he apportioned 100% to the December 27, 2012 injury. (*Id.* at p. 29.)

In his supplemental report dated January 20, 2021, after reviewing the comprehensive medical and vocational records, as well as the submitted surveillance video footage, he confirmed his prior medical opinions remained unchanged, while recommending that the determination of vocational feasibility required the additional input of a pain management specialist. (Joint Ex. 1, pp. 9-11.)

In his report dated October 6, 2016, QME Dr. Lineback, after evaluating applicant in the field on internal medicine, diagnosed him with a severely comminuted left calcaneus fracture, subsequent methicillin-resistant Staphylococcus aureus infection, chronic osteomyelitis, and compensatory right knee strain, lumbosacral strain, and left shoulder tendinitis. (Joint Ex. 16, pp. 9, 15, 16, 20, 22, 24-26, 29, 32, 35-36, 41.) Objective findings demonstrated exhibited elevated blood pressure measurements of 155/104 during the examination, alongside a height of 5 feet 5 inches and weight of 230 pounds. (*Id.* at p. 5.)

In his supplemental report dated January 8, 2017, QME Dr. Lineback reviewed applicant's records from Torrance Memorial Medical Center evidencing diagnoses including coronary artery disease, hypertension, and status post coronary angioplasty with stent placement following an acute myocardial infarction on April 4, 2015. (Joint Ex. 15, pp. 2, 8-9, 10.) Objective measurements from the hospitalization confirm blood pressure readings as high as 227/145, an echocardiogram showing a left ventricular ejection fraction of 55 to 60%, and an angiogram revealing a 90% proximal stenosis of the left anterior descending artery. (*Id.* at pp. 4-5, 9-10.) QME Dr. Lineback concluded applicant's severe hypertension developed directly from the physiological and emotional stress of the chronic pain and repeated surgeries related to the left foot, which subsequently caused the acute myocardial infarction. (*Id.* at p. 10.) QME Dr. Lineback deemed applicant permanent and stationary and assigned, based on the objective measurements, for the hypertension, 9% WPI based on Class 1 impairment (AMA Guides, Table 4-2, p. 66) and,

for the coronary artery disease, 20% WPI based on Class 2 impairment. (AMA Guides, Table 3-6a, p. 36.) (*Id.* at pp. 9, 11.) For apportionment, QME Dr. Lineback attributed 10% of the disability for both the hypertension and the coronary artery disease to the non-industrial risk factor of obesity based on his height and weight, with 90% to the December 27, 2012 injury. (*Id.* at p. 11.)

In his report dated April 2, 2019, QME Dr. Agatstein, after evaluating applicant in the field of urology, diagnosed him with erectile dysfunction, hypertension, elevated cholesterol, status post myocardial infarction, obesity, chronic narcotic opiate use, and depression. (Joint Ex. 5, pp. 12-13.) During the physical examination, QME Dr. Agatstein recorded objective measurements, including a blood pressure of 189/89, a body mass index of 41.5, and a 30-cm. scar on the left foot accompanied by objectively decreased dorsiflexion and diminished sensation. (*Id.* at p. 7.) Diagnostic testing yielded objective urological findings featuring an International Index of Erectile Function score of 10, which indicate moderate erectile dysfunction, alongside non-invasive uroflowmetry demonstrating a maximum flow rate of 34.9 ml/second with a zero post-void residual. (*Id.* at pp. 6-7.)

He deemed applicant permanent and stationary and assessed 9% WPI based on Class 1 impairment in light of his diagnostic testing. (AMA Guides, Table 7-5, p. 156.) For apportionment, QME Dr. Agatstein attributed 40% of the erectile dysfunction to the December 27, 2012 injury, 10% from industrial depression, and 10% from opiate-induced testosterone suppression necessitated by December 27, 2012 injury, and deferring the industrial apportionment of the remaining 40%, with 10% each, caused by hypertension, obesity, cholesterol, and coronary artery disease, to an internist. (*Id.* at pp. 13.)

In his medical report dated November 7, 2017, QME Dr. Tang, after evaluating applicant in the field of psychiatry, diagnosed him with an adjustment disorder with mixed anxiety and depressed mood. (Joint Ex. 11, p. 10.) Objective clinical findings during the mental status examination included a flat range of affect, an antalgic gait requiring a left foot brace, and cognitive deficits marked by an inability to spell the word "world" backward or recall more than one out of three objects after five minutes. (*Id.* at pp. 5, 9-10.) Objective psychometric measurements demonstrated profound emotional distress, with the Beck Anxiety Inventory yielding a score of 43 for severe anxiety and the Beck Depression Inventory yielding a score of 35 for severe depression. (*Id.* at pp. 14-15.)

In his re-evaluation report dated November 9, 2019, QME Dr. Tang updated applicant's diagnosis to a single episode of major depressive disorder. (Joint Ex. 10, p. 7.) Objective findings at this examination reveal a restricted affect, an ongoing depressed and anxious mood, and a continuing reliance on a left foot brace due to severe chronic pain. (*Id.* at pp. 6-7, 14.) Although applicant's cognitive concentration and memory measurements showed slight clinical improvement, recalling two out of three objects and correctly spelling "world" backward, his subjective psychometric measurements remained elevated, with a Beck Anxiety Inventory score of 36 indicating severe anxiety and a Beck Depression Inventory score of 21 indicating moderate depression. (*Id.* at pp. 7, 9.) The Minnesota Multiphasic Personality Inventory-2-Restructured Form produced an invalid profile due to an elevated over-reporting scale score of 120. (*Id.* at pp. 8, 10.)

QME Dr. Tang deemed applicant permanent and stationary as of October 23, 2019 and assessed a Global Assessment of Functioning score of 59 or 17% WPI. (*Id.* at pp. 2, 7, 10.) QME Dr. Tang attributed 100% of the permanent disability to the December 27, 2012 injury. (*Id.* at p. 11.)

In his supplemental reports dated December 27, 2019, and March 9, 2020, he completed a Work Function Impairment Form assigning slight impairments in the ability to comprehend and follow instructions and maintain a work pace, alongside moderate impairments in performing simple and repetitive tasks, performing complex tasks, relating to others, influencing people, making independent decisions, and accepting responsibility. (Joint Ex. 9, p. 2.) Objective psychometric findings documented on page 4 of the March 2020 report include a Beck Depression Inventory score of 23 indicating moderate depression, a Beck Anxiety Inventory score of 36 indicating severe anxiety, and a Test of Memory Malingering that confirms applicant provided significant effort without exaggerating symptoms. (Joint Ex. 8, p. 4.)

While QME Dr. Tang noted that the Minnesota Multiphasic Personality Inventory-2-Restructured Form yielded an invalid profile due to an elevated F-r validity scale score of 120 indicating extreme over-reporting, the broader objective findings confirm a somber affect, a moderately depressed and anxious mood, and a slow gait utilizing a left foot boot. (Joint Ex. 9, p. 3; Joint Ex. 8, p. 5.)

Based on the QME reports, the permanent disability rating strings are as follows:

LEFT SHOULDER – RANGE OF MOTION

090% (16.02.01.00 - 08 - [7]11 - 380H - 14 - 15%) 14%
LUMBAR SPINE – DIAGNOSIS-RELATED ESTIMATE
090% (15.03.01.00 - 06 - [5]08 - 380H - 11 - 12%) 11%
LEFT KNEE – MUSCLE STRENGTH
090% (17.05.05.00 - 07 - [2]08 - 380I - 12 - 13%) 12%
LEFT ANKLE – STATION AND GAIT DISORDERS
100% (13.08.00.00 - 35 - [5]45 - 380I - 54 - 56%) 56%
HYPERTENSION CARDIOVASCULAR DISEASE
090% (04.01.00.00 - 09 - [5]11 - 380H - 14 - 15%) 14%
CORONARY HEART DISEASE
090% (03.02.00.00 - 20 - [5]25 - 380H - 30 - 32%) 29%
REPRODUCTIVE SYSTEM
060% (07.05.00.00 - 09 - [2]10 - 380F - 10 - 11%) 07%
PSYCHIATRIC – MENTAL AND BEHAVIORAL
100% (14.01.00.00 - 17 - [8]24 - 380H - 29 - 31%) 31%
56 C 31 C 29 C 14 C 14 C 12 C 11 C 07 = 89% permanent disability

In his vocational report dated May 19, 2020, Mr. Largo, after evaluating applicant by video conference, took a history that applicant graduated from high school in 1988, obtained an Associate of Arts degree in General Studies from a community college in 1992, and withdrew from a police academy training program for academic reasons in 1995. (App. Ex. 12, p. 4.) In addition to the work restrictions from QME Dr. Luciano, Mr. Largo evaluated applicant's cognitive abilities and found impaired concentration and ability to focus which he attributed to medication side effects including dizziness and drowsiness from opiate pain relievers. (*Id.* at p. 31.) Mr. Largo analyzed the open labor market and cited Employment Development Department data showing the seasonally adjusted unemployment rate in the County of Los Angeles increased to 6.3% in March 2020. (*Id.* at p. 39.) Mr. Largo concluded as follows:

> Mr. Alegria presents complex medical issues. Mr. Alegria presents orthopedic, internal, urological, and psychiatric impairment, in addition to issues with respect to chronic pain and medication side effects. When considering the medical records provided for this consultant's review and consideration, it is this consultant's opinion, within a reasonable degree of vocational certainty, Mr. Alegria is not amenable to vocational rehabilitation and is unable to return to the open labor market.

(*Id.* at p. 43.)

With respect to apportionment, Mr. Largo also concluded as follows:

> When considering apportionment as noted in the medical records and Mr. Alegria's work history, it is this consultant's opinion Mr. Alegria's inability to benefit from vocational rehabilitation and inability to return to the open labor market is 100% industrial in nature. Mr. Alegria was able to continue in his job duties with J. F. Electrical, Inc., given any pre-existing or non-industrial medical conditions. The

> medical providers have apportioned, to a significant degree, Mr. Alegria's impairment to the industrial injury.

(*Id.* at p. 49.)

In her vocational assessment report dated November 20, 2020, Ms. Perez, after evaluating applicant, assessed his cognitive capabilities and identified average general learning ability average English vocabulary and above average spelling alongside below-average English reading comprehension and a typing speed of six correct words per minute. (App. Ex. 10, p. 10.) She observed his physical capabilities and noted he elevated his left leg on a chair for approximately 35% of the scheduled evaluation and utilized a brace. (*Id*. at p. 4.) She documented that he participated in 73% of the scheduled evaluation time and incurred early departures on the second and third days due to severe reported pain and lack of sleep. (*Id.* at p. 3.) The assessment revealed he experienced severe concentration difficulties by the early afternoon of each day leading her to document his statement that he is not ready to return to work. (*Id.* at pp. 5, 10.)

In his supplemental report dated December 3, 2020, Mr. Largo administered formal psychometric testing measures applicant's cognitive and clerical skills, revealing average general learning ability and spelling skills, but below-average English reading comprehension, below-average rapid proofreading abilities, below-average mechanical-spatial skills, a typing speed of only six correct words per minute, and limited Microsoft Word proficiency. (App. Ex. 11, p. 4.) During the three-day vocational testing process by Ms. Perez on November 20, 2020, applicant demonstrated severe pain behaviors and limited physical tolerances preventing him from completing it. (*Id.* at p. 3.) Mr. Largo reviewed sub rosa video on August 25, 2020 showing applicant walking a dog and driving a vehicle but found these brief activities did not demonstrate an ability to sustain full time employment or contradict the severe pain levels reported during and after such activities. (*Id.* at pp. 4-7, 15.)

In his vocational evaluation and rebuttal reports both dated September 16, 2020, Mr. Meyers conducted an interview of applicant over Zoom and performed vocational testing on August 17, 2020, including multiple psychometric tests to evaluate cognitive capabilities. On the Raven Standard Progressive Matrices, he scored at the 19th percentile for abstract reasoning. On the Wide Range Achievement Test 5, he achieved a standard score of 93, representing a 7.2 grade equivalent in math computation, and a standard score of 106, representing a greater than 12.9 grade equivalent in word reading. (Def. Ex. A, p. 13.) On the Career Ability Placement Survey, he scored below average in mechanical reasoning, language usage, word knowledge, and manual speed, and

scored low or very low in spatial relations, verbal reasoning, and perceptual speed. (*Id.* at pp. 13-14.) Mr. Meyers concluded that these testing results indicated applicant could learn new job tasks effectively on the job. (*Id.* at p. 26.) Regarding physical capabilities, Mr. Meyers recorded applicant's responses that he can lift 15 to 20 pounds comfortably and tolerate 30 minutes of sitting, standing, walking, and driving. (*Id.* at pp. 16-17.) Mr. Meyers reviewed sub rosa video of applicant as well as the work restrictions set forth by QME Dr. Luciano. (*Id.* at pp. 12-13, 26.) Mr. Meyers determined that applicant retained the physical capacity to perform a full range of sedentary work and an eroded range of light work, noting that the sub rosa video supported access to light jobs. (*Id.* at p. 26.) Mr. Meyers, considering QME Dr. Tang's GAF score of 59 for applicant, determined that an individual with a score of 59 could perform unskilled entry-level work and some semi-skilled work. (*Id.* at pp. 27-28.) Mr. Meyers emphasized in his rebuttal report that no physician prescribed any work restrictions for applicant based on his pain or medication side effects. (Def. Ex. B, p. 4.)

Mr. Meyers conducted a labor market survey and processed an analysis of transferable skills using OccuBrowse software based on applicant's 15 years of experience as an electrician. The analysis identified semi-skilled job matches with high transferability, including service dispatcher, wire harness assembler, coil winder, electrical continuity tester, and lamination assembler, along with an unskilled option as a parking lot attendant. (Def. A, pp. 31-32.) Mr. Meyers conducted labor market research utilizing data from the California Labor Market Information Division for the County of Los Angeles, which projected substantial employment numbers for 2026, specifically 7,140 service dispatchers, 4,010 assemblers, and 13,910 parking lot attendants. (*Id.* at p. 32.) Mr. Myers noted that applicant is bilingual in English and Spanish, which represented a significant vocational asset that increased the probability of finding employment based on a 2017 employment study. (*Id.* at pp. 24-25.) Based on the available job opportunities and the residual physical and psychiatric capacities, Mr. Meyers concluded that applicant was feasible and amenable to vocational rehabilitation through a direct job placement plan or on-the-job training. (*Id.* at p. 33.) Consequently, Mr. Meyers concluded that applicant has not rebutted the permanent disability rating schedule (PDRS) due to vocational nonfeasance. (*Id.* at p. 34.)

On May 24, 2022, the WCJ issued the FA&O, finding applicant sustained 100% permanent disability without apportionment.

In the Opinion on Decision, the WCJ stated as follows:

> To address apportionment, Mr. Largo's initial report considered the multiple medical legal reports and other medical records' apportionment discussions and concludes, "When considering apportionment as noted in the medical records and Mr. Alegria's work history, it is this consultant's opinion Mr. Alegria's inability to benefit from vocational rehabilitation and inability to return to the open labor market is 100% industrial in nature." (Applicant's Exhibit 12, page 49.)
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> * * *
>
> Of great significance is Mr. Largo's incorporation of the fact that applicant's pain medication, used in the treatment of chronic pain, is a predominant factor as to applicant's amenability to vocational rehabilitation. Further, this assessment is supported by the discussion of orthopedic QME Dr. Luciano, QME Dr. Tang, Dr. Friedman and Dr. Vally.
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> * * *
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> Based on this evidence, the WCJ does not find a legal basis to apportion applicant's permanent total disability award.
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> * * *
>
> The WCJ gave great weight to Mr. Largo's report along with the medical records reviewed, which lead to the conclusion that the applicant is not able to return to any substantial or gainful employment or able to compete in the open labor market rendering him 100% disabled.

(Opinion on Decision, pp. 12-13.)

It is from this FA&O that defendant seeks reconsideration.

DISCUSSION

I.

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 the issue of whether an applicant is permanently and totally disabled must be determined through impairment ratings by application of the AMA Guides pursuant to Labor Code section 4660[2].

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

In addition, a finding under section 4662(b), "in accordance with the fact," does not provide a second independent path to permanent total disability separate from section 4660. (*Id.* at p. 622; *Bermejo v. Jorge Castro Farms* [2019 Cal. Wrk. Comp. P.D. LEXIS 93, *18-19].)[3]

However, an employee may challenge the scheduled permanent disability rating by proving a calculation error or an omission of medical complications, or that the injury prevents rehabilitation and causes a greater loss of future earning capacity than the PDRS reflects. (*Fitzpatrick*, *supra*, *27* Cal.App.5th at pp. 613-614 and 618-620; see *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1274 [76 Cal.Comp.Cases 624]; *Contra Costa County v. Workers' Comp. Appeals Bd.* (*Dahl*) (2015) 240 Cal.App.4th 746, 758 [80 Cal.Comp.Cases 1119]; *LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234, 245-246 [48 Cal.Comp.Cases 587].)

With respect to vocational evidence, where an employee's work restrictions due to industrial factors cause the loss of their ability to compete for jobs on the open labor market, this would result in a total loss of earning capacity and permanent total disability. (*Dahl*, *supra*, 240 Cal.App.4th at p. 757; *LeBoeuf*, *supra*, 34 Cal.3d at pp. 245-246; *Soormi v. Foster Farms* [2023 Cal. Wrk. Comp. P.D. LEXIS 170, *11-12] citing *Wilson v. Kohls Dep't Store* [2021 Cal. Wrk. Comp. P.D. LEXIS 322, *20–23.].)

In *LeBoeuf*, the Supreme Court applied a standard of labor market reality stating that, "A permanent disability rating should reflect as accurately as possible an injured employee's diminished ability to compete in the open labor market. The fact that a worker has been precluded from vocational retraining is a significant factor to be taken into account in evaluating his or her potential employability." (*LeBouef*, *supra*, 34 Cal.3d at pp. 245-246.) The Court concluded, "This is to ensure that the permanent disability rating upon which an award is based accurately reflects both the permanent medical and vocational disabilities." (*Id.* at p. 243.)

[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.

Accordingly, to rebut the PDRS and establish permanent total disability, applicant must prove the following:

1) Applicant has received a work restriction(s), which requires substantial medical evidence.
2) The work restriction(s) precludes applicant from rehabilitation into another career field, which requires vocational expert evidence.
3) The work restriction(s) precludes applicant from competing on the open labor market, which requires vocational expert evidence.
4) The cause of the work restriction(s) is 100% industrial, which requires substantial medical evidence.

(*Valdovinos v. Universal Site Services, Inc.* [2025 Cal. Wrk. Comp. P.D. LEXIS 76, *14]; *Fiore v. Los Angeles Community College District* [2024 Cal. Wrk. Comp. P.D. LEXIS 297, *16-17].)

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 or vocational 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 and vocational 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 or vocational opinion cannot support the Appeals Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].)

Finally, the law authorizes the Appeals Board to consider "[r]eports of attending or examining physicians." (Lab. Code, § 5703(a); *Valdez v. Workers' Comp. Appeals Bd.* (2013) 57 Cal.4th 1231, 1239 [78 Cal.Comp.Cases 1209].) Section 4064(d) does not prohibit a party from obtaining *any* medical evaluation or consultation at their own expense, and provides that *all* comprehensive medical evaluations obtained shall be admissible in any proceeding before

the Appeals Board except as provided in specified statutes. (Lab. Code, § 4064(d); *Valdez*, *supra*, 57 Cal.4th at p. 1239.)

Here, applicant successfully rebutted the PDRS and established permanent total disability. While not binding, the four-prong standard set forth in *Valdovinos* and *Fiore* is applicable here, and applicant has satisfied each of the prongs. First, applicant demonstrated work restrictions supported by substantial medical evidence, encompassing not only his orthopedic limitations as set forth by QME Dr. Luciano but also the severe cognitive and psychiatric restrictions stemming from his chronic pain and narcotic regimen as set forth by Dr. Vally. The reporting constitutes substantial medical evidence because it does not rest upon mere conjecture. Rather, it is anchored in an adequate longitudinal treatment history, documents objective clinical manifestations of complex regional pain syndrome, including localized edema, muscle spasms, and vasomotor changes, and clearly articulates the pharmacological nexus between applicant's industrially necessitated opioid regimen and his profound cognitive deficits. Second and third, applicant relied on the vocational expert testimony of Mr. Largo under *LeBoeuf* to prove that these comprehensive work restrictions entirely preclude both his rehabilitation into another career field and his ability to compete on the open labor market. Defendant heavily relies on the reporting of its vocational expert, Mr. Meyers, who concluded applicant remained amenable to rehabilitation. However, Mr. Meyers' analysis fails to constitute substantial evidence because it artificially isolates applicant's orthopedic restrictions while ignoring the compounding reality of his chronic pain and medication side effects maintaining they involve no work restrictions. Conversely, Mr. Largo properly synthesized the entirety of applicant's complex medical presentation and accurately assessed his vocational preclusion. Finally, satisfying the fourth prong, substantial medical evidence establishes that the specific work restrictions precluding applicant's vocational feasibility are entirely industrial. As discussed in paragraph II, the record demonstrates that, even when accounting for underlying orthopedic apportionment, the purely industrial factors, the psychiatric injury and the severe cognitive side effects of the opioid regimen, act as independent and autonomous causes of applicant's total loss of earning capacity.

While the dissent correctly notes Dr. Vally's February 24, 2021 report lacked a contemporaneous physical examination due to pandemic restrictions, we must evaluate a medical opinion in its totality. Dr. Vally's June 3, 2020 examination documented extensive objective findings, including muscle spasms, edema, and color changes indicative of complex regional pain

syndrome. The February 24, 2021 report is an extension of this established clinical baseline, focusing primarily on the cognitive impacts of applicant's documented opioid regimen. Therefore, the lack of a physical exam does not render the cognitive and pharmaceutical findings speculative.

Furthermore, defendant's attempt to characterize the reporting of applicant's pain management physician, Dr. Vally, as inadmissible and insubstantial misconstrues both the evidentiary record and the applicable statutory framework. While defendant asserts that Dr. Vally failed to report to the primary treating physician and conduct a physical examination for his permanent disability findings, the record demonstrates that he treated applicant extensively as an attending physician and recorded significant objective findings of complex regional pain syndrome during prior evaluations. The lack of an in-person physical examination for the final report resulted strictly from mandatory COVID-19 pandemic protocols, not medical negligence. More importantly, QME Dr. Luciano explicitly deferred the ultimate determination of applicant's vocational feasibility to a pain management physician. This deferral rendered Dr. Vally's conclusions regarding the cognitive deficits and drowsiness induced by the opioid regimen essential to the final disability determination. Evaluating the complete medical picture under these broad admissibility standards, the WCJ correctly utilized Mr. Largo's vocational analysis and Dr. Vally's medical reporting to establish a 100% loss of earning capacity.

II.

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.].)

A physician must determine apportionment based on causation of physical disability, because an employer is liable solely for the portion of permanent disability directly attributable to an injury arising out of and occurring in the course of employment. (Lab. Code, §§ 4663(a) and 4664(a).) "The plain reading of 'causation' in this context is causation of the permanent disability." (*Escobedo, supra,* 70 Cal.Comp.Cases at p. 611.) To comply with section 4663, a physician must do more than simply state the cause of disability and assign approximate percentages of industrial and nonindustrial contribution. (*E.L. Yeager Construction v. Workers' Comp. Appeals Bd.* (*Gatten*) (2006) 145 Cal.App.4th 922, 927-928 [71 Cal.Comp.Cases 1687]; *Mills v. State Comp.*

Ins. Fund (2025) 91 Cal.Comp.Cases 64, 68 [2025 Cal. Wrk. Comp. P.D. LEXIS 305]; *Anaya v. State Dep't of Corr.* [2022 Cal. Wrk.Comp. P.D. LEXIS 262, *23].) A proper apportionment analysis requires the physician to first identify all factors contributing to applicant's permanent disability, both prior to and following the industrial injury, and then determine the approximate percentage of overall permanent disability attributable to each factor. (*Mills*, *supra*, 91 Cal.Comp.Cases at p. 69.)

Apportionment now includes pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions, provided there is substantial evidence establishing that these other factors have caused permanent disability. Pursuant to *Escobedo*, a physician's opinion must constitute reasonable medical probability, must not be speculative, rely on pertinent facts and/or an adequate examination and history, and must set forth the reasoning in support of the conclusions. (*Id.* at p. 621.) That is, a physician must explain the "how and why" of their apportionment opinion and consider all potential causes of disability, whether from a current, prior or subsequent industrial or nonindustrial injury or condition. (*Ibid.; Benson v. Permanente Med. Group* (2007) 72 Cal.Comp.Cases 1620, 1622 (Appeals Board en banc).)

In explaining the "how and why" of apportionment to a preexisting condition, a physician must demonstrate that, even absent the industrial injury, a portion of the disability would have resulted from the natural progression of the underlying condition. (See *Pullman Kellogg v. Workers' Comp. Appeals Bd.* (*Normand*) (1980) 26 Cal.3d 450, 454 [45 Cal.Comp.Cases 170].)

To accurately delineate this "how and why" and avoid circular reasoning, a physician must distinctly separate the two concepts. The "why" represents the statutory justification requiring a physician to fulfill this requirement simply by referencing sections 4663 and 4664 to acknowledge the legislative mandate for apportionment. The "how" represents the clinical mechanism where the expert must detail the exact manner in which a specific non-industrial factor resulted in the disability and quantify that causation with an approximate percentage. Lay testimony or broad conclusions cannot substitute for scientific medical knowledge. (*Peter Kiewit Sons v. I.A.C.* (1965) 234 Cal.App.2d 831, 838 [30 Cal.Comp.Cases 188].) Ultimately, this substantial medical evidence is required to enable a WCJ to objectively evaluate the claim and disregard medical opinions based on speculation, inadequate medical histories, or incorrect legal theories. (*Hegglin*, *supra*, 4 Cal.3d at p. 169.)

Where some portion of an employee's permanent disability results from a preexisting, asymptomatic condition caused by a nonindustrial disease or pathology, by congenital or genetic factors, or by other non-industrial risk factors, a physician may permissibly apportion the permanent disability. (*Brophy v. Workers' Comp. Appeals Bd.* (2021) 86 Cal.Comp.Cases 706, 707 (writ den.); see e.g., *City of Jackson v. Workers' Comp. Appeals Bd.* (*Rice*) (2017) 11 Cal.App.5th 109 [82 Cal.Comp.Cases 437] [allowing apportionment of permanent disability caused by genetic or congenital cervical spine pathology]; *Acme Steel v. Workers' Comp. Appeals Bd.* (*Borman*) (2013) 218 Cal.App.4th 1137 [78 Cal.Comp.Cases 751] [allowing hearing disability to be apportioned to congenital degeneration of the cochlea].) In *City of Petaluma v. Workers' Comp. Appeals Board* (*Lindh*) (2018) 29 Cal.App.5th 1175 [83 Cal.Comp.Cases 1869], the Court of Appeal clarified that the relevant inquiry is the causation of permanent disability, not the causation of the injury. Because the medical evidence demonstrated that the employee's underlying vasospastic condition and vasculature directly contributed to his impaired vision, it constituted a legally valid basis for apportionment, regardless of whether the condition was asymptomatic before the industrial injury. (*Id.* at p. 1193.)

Notwithstanding *Lindh*, the Appeals Board strictly rejected apportionment when a pre-existing condition merely serves as a risk factor for sustaining and industrial injury rather than directly causing permanent disability. In *State of California/Department of Hospitals-Vacaville v. Workers' Comp. Appeals Bd.* (*Ham*) (2019) 84 Cal.Comp.Cases 1006 (writ den.), the Appeals Board concluded that a physician's attempt to apportion 50% of an employee's disability to nonindustrial diabetes did not rely on substantial medical evidence. Because the diabetes merely predisposed the employee to an industrial MRSA infection, which subsequently required a foot amputation, the industrial injury and resulting amputation exclusively caused the permanent orthopedic disability. Similarly, in *Wiest v. Cal. Dep't of Corr.* (2021) 86 Cal.Comp.Cases 856, the Appeals Board upheld the rejection of apportionment for pre-existing diabetes that led to bilateral below-the-knee amputations, emphasizing that the permanent disability rating evaluated the orthopedic impairments of the amputations rather than any underlying diabetic impairment. *Wiest* explicitly distinguishes *Lindh* by highlighting that an underlying condition legally justifies apportionment only when a physician identifies it as an active, contributing cause of the permanent disability itself. Thus, in harmonizing these decisions, physicians may apportion to a nonindustrial risk factor only when they provide substantial medical evidence detailing "how and why" that

specific condition directly causes the permanent disability, just as the underlying vasospastic condition directly contributed to the vision loss in *Lindh*. They may not legally apportion permanent disability to a nonindustrial risk factor that solely increases an employee's susceptibility to a workplace injury because this confuses causation of injury with causation of permanent disability. (*Valencia v. City of Daly City* [2025 Cal. Wrk. Comp. P.D. LEXIS 6, *15]; *Arias v. Williams Roofing Co.* [2024 Cal. Wrk. Comp. P.D. LEXIS 29, *10-11]; *Junge v. City of San Jose* [2021 Cal. Wrk. Comp. P.D. LEXIS 375, *17].)

Ultimately, the burden of proof to establish apportionment falls on defendant. (*Id.* at p. 456; *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1115 [71 Cal.Comp.Cases 1229].) In other words, an employee does not have the burden of disproving apportionment while defendant remains passive. (*Alcantar v. Martinez* [2025 Cal. Wrk. Comp. P.D. LEXIS 231, *9]; *Moraido v. County of San Diego* [2024 Cal. Wrk. Comp. P.D. LEXIS 375, *13, fn. 3]; *Arias v. William Roofing Co.* [2024 Cal. Wrk. Comp. P.D. LEXIS 29. *5]; *Matias v. Naturipe Berry Growers* [2024 Cal. Wrk. Comp. P.D. LEXIS 52, *4]; *Herrera v. Maple Leaf Foods* [2018 Cal. Wrk. Comp. P.D. LEXIS 430, *15].)

With respect to vocational expert evidence, pursuant to *Nunes v. State of California, Dept. of Motor Vehicles* (2023) 88 Cal.Comp.Cases 741 (Appeals Board en banc) (*Nunes I*), the Appeals Board held as follows:

1. Section 4663 requires a reporting physician to make an apportionment determination and prescribes the standard for apportionment. The Labor Code makes no statutory provision for "vocational apportionment."

2. Vocational evidence may address issues relevant to the determination of permanent disability.

3. Vocational evidence must address apportionment, and may not substitute impermissible "vocational apportionment" in place of otherwise valid medical apportionment.

(*Id.* at pp. 743-744.)

In addition, "[v]ocational evidence may also be used to parse permanent disability caused by multiple body parts or systems" to determine if applicant's permanent total disability was related to a single body part. (*Id.* at pp. 751-752.) In other words, "a finding of permanent and total disability notwithstanding the presence of valid nonindustrial apportionment is permissible, so long as the medical and vocational evidence establishes that the permanent and total disability

arises solely out of industrial conditions or factors, that is, exclusive of nonindustrial or prior industrial conditions or factors." (*Nunes v. State of California, Dept. of Motor Vehicles* (2023) 88 Cal.Comp.Cases 894, 900 (Appeals Board en banc) (*Nunes II*); see *Pacific Compensation Insurance Co. v. Workers' Comp. Appeals Bd.* (*Nilsen*) (2013) 78 Cal.Comp.Cases 722, 726-727 (writ den.) ["[T]he fact that there is apportionment of the disability as to one (or more) parts of body does not mean that the totality of purely industrial factors cannot by themselves render a worker totally disabled."].)

The Appeals Board noted that it "does not require the application of invalid apportionment by the parties or by the WCJ, and in those instances where there is a significant question as to the validity of a physician's medical apportionment opinion, the vocational expert is free to offer their analysis in the alternative." (*Nunes II, supra*, 78 Cal.Comp.Cases at p. 903.)

Our en banc decision in *Nunes I* issued on June 22, 2023, after our Opinion and Order Granting Petition for Reconsideration dated August 19, 2022, and is mandatory authority on all WCJs and WCAB panels. (Cal. Code Regs., tit. 8, § 10325(a); *City of Long Beach v. Workers' Comp. Appeals Bd. (Garcia)* (2005) 126 Cal.App.4th 298, 316, fn. 5; *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1424, fn. 6; see also Govt. Code, § 11425.60(b).)

Accordingly, to constitute substantial evidence, the opinions of both the evaluating physician and the vocational expert must set forth the history and evidentiary basis for their conclusions, including an explanation of "how and why" a condition or factor results in permanent disability. (*Nunes I*, *supra*, at p. 896.)

In this case, we must reject the medical apportionment determinations provided by three evaluating QMEs, as none rise to the level of substantial medical evidence required by section 4663 and *Escobedo*. QME Dr. Luciano attempted to apportion 10% of applicant's left shoulder, lumbar spine, and right knee disability to non-industrial "activities associated with daily living." This formulation is legally invalid. Unspecified ADLs do not inherently constitute a pathology, disease, or prior condition under the expanded "other factors" contemplated by section 4663. QME Dr. Luciano failed to identify which specific activities caused distinct anatomical conditions and entirely omitted the mandatory "how and why" analysis connecting these routine activities to applicant's permanent disability.

Similarly, QMEs Dr. Lineback and Dr. Agatstein failed to provide legally sufficient apportionment. Dr. Lineback apportioned 10% of applicant's hypertension and coronary artery

disease merely to the non-industrial risk factor of obesity. As previously discussed, identifying a generalized risk factor or physical susceptibility without explicitly detailing the clinical mechanism by which it actively caused the permanent disability impermissibly conflates the causation of an injury with the causation of disability. Furthermore, QME Dr. Agatstein's attempt to apportion 40% of applicant's erectile dysfunction to a combination of hypertension, obesity, cholesterol, and coronary artery disease is legally defective because it explicitly defers the actual industrial, non-industrial breakdown of those underlying conditions to an internist. An incomplete, deferred medical opinion cannot serve as substantial evidence. Consequently, the evidentiary record is devoid of valid medical apportionment.

Defendant argues that Mr. Largo impermissibly substituted his own judgment to override the medical apportionment assigned by the QMEs. This argument fundamentally fails to apprehend the mechanics of vocational analysis under *Nunes II*. Because the medical apportionment provided by QMEs Dr. Luciano, Dr. Lineback, and Dr. Agatstein was legally invalid and lacked substantial medical evidence, Mr. Largo was not strictly bound to incorporate their flawed percentages into his labor market analysis.

Under *Nunes II*, Mr. Largo properly offered an alternative analysis grounded exclusively in the purely industrial factors. He did not evaluate the clinical significance of the medical apportionment. Rather, he concluded that the 100% industrial components, specifically, the severe cognitive side effects of the industrially necessitated opioid medications and the entirely industrial psychiatric injury established by Dr. Friedman, independently render applicant permanently totally disabled. The law permits a finding of permanent total disability when the vocational and medical evidence establishes that the purely industrial conditions autonomously cause the total loss of earning capacity. The WCJ correctly determined that applicant's industrial medication side effects and psychiatric decline pushed his vocational non-feasibility over the top, independently justifying the unapportioned 100% award based on a proper alternative vocational analysis.

Accordingly, as our Decision After Reconsideration, we will affirm the FA&O.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings and Order and Award issued on May 24, 2022 by the WCJ is **AFFIRMED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

I DISSENT (See Dissenting Opinion),

/s/ JOSÉ H. RAZO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

OCTOBER 8, 2026

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

JUAN ALEGRIA
MAURICE L. ABARR-LAWYER, INC.
GUILFORD SARVAS & CARBONARA LLP

DLP/md

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

DISSENTING OPINION OF COMMISSIONER JOSÉ H. RAZO

I respectfully dissent. I would rescind the FA&O, and find that the vocational rehabilitation reporting of Mr. Largo fails to successfully rebut the 2005 PDRS and award 89% permanent disability. Applicant's unapportioned permanent total disability award rests on fundamentally flawed vocational and medical analyses that improperly evade the mandate of apportionment by holding the QMEs to an impossible standard of exactitude.

Mr. Largo's vocational opinion is not substantial evidence because it lacks the foundational rigor required for a proper labor market analysis. Unlike the reporting provided by defendant's vocational expert, Mr. Meyers, who conducted a comprehensive analysis of applicant's transferable skills, the availability of employment within those constraints, and the impact of nonindustrial factors on the labor market, Mr. Largo's opinion is devoid of any such comparative, systematic methodology. Mr. Largo's analysis lacks an independent evidentiary foundation, relying instead on the procedurally deficient findings of Dr. Vally to bridge the gap toward a 100% permanent disability determination. By relying on an uncoordinated secondary report that circumvented the primary treating physician framework and lacked a contemporaneous physical examination, Mr. Largo's vocational conclusions are foundationally unsound. An opinion that ignores the multispecialty QME consensus to favor a single, procedurally defective medical report, while failing to articulate a standard labor market analysis, is inherently speculative and fails to meet the rigorous standard of substantial evidence required to support a 100% permanent disability award.

Furthermore, section 4663(c) strictly requires that permanent disability be apportioned based on causation, reflecting a clear legislative intent to permit apportionment to pathology and underlying conditions. (*Gatten*, *supra*, 145 Cal.App.4th at p. 927.) I fully concur with the holding in *Lindh* and its attendant implications. Specifically, risk factor for an injury can concurrently operate as the causal factors of an injured employee's permanent disability. In this matter, multiple QMEs provided legally valid determinations of non-industrial medical apportionment based on applicant's established medical history, including morbid obesity and nonindustrial degenerative changes. The majority fails to observe the critical legal distinction between the causation of an industrial injury and the causation of permanent disability. Under *Lindh*, the fact that a condition like morbid obesity acts as a risk factor predisposing an injured employee to injury does not legally preclude a physician from determining that the exact same condition is concurrently a direct causal

factor of the resulting permanent disability. The majority improperly invalidates these clinical findings by subjecting the QMEs' "how and why" analyses to an impossible standard of exactitude. Demanding mathematical precision places a near-impossible burden on an examining physician and directly contradicts the standard imposed by the Legislature in section 4663(c), which explicitly requires only that a physician determine the "approximate" percentage of permanent disability. (*Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 621.) As articulated in *Gatten*, when an expert makes a determination of the approximate percentage of permanent disability caused by other factors based on their subjective medical expertise, "it is not a mere random number," and section 4663(c), "requires no more." (*Gatten*, *supra*, 145 Cal.App.4th at p. 930.) By rejecting these medical opinions for a lack of absolute perfection, the majority impermissibly substitutes its own judgment for that of the QMEs and strips them of their statutory authority to approximate apportionment.

Emboldened by this erasure of the medical record, vocational expert Mr. Largo effectively dismissed the established medical apportionment to construct a 100% industrial loss of earning capacity. Weighing the clinical validity of medical apportionment explicitly exceeds the authority and expertise of a vocational expert. By unilaterally ignoring the QMEs' apportionment findings, Mr. Largo engaged in legally impermissible vocational apportionment, directly violating the Appeals Board's mandate in *Nunes I*.

The WCJ compounded this error by relying on a secondary treating physician, Dr. Vally, to bypass the apportionment determinations of the QMEs entirely. While Dr. Vally's reporting may clear the baseline threshold for admissibility, it falls demonstrably short of the substantial medical evidence required to support a 100% unapportioned award. Dr. Vally never submitted his reports to the primary treating physician, effectively operating outside the coordinated medical treatment framework. More critically, he failed to conduct a physical examination of applicant for the very report that declared him permanently and totally disabled. An uncoordinated secondary medical report lacking a contemporaneous physical examination cannot serve as the substantial medical evidence necessary to override the valid apportionment established by multiple evaluating QMEs.

My central point of departure with the majority lies in the characterization of Dr. Vally's medical report within the broader evidentiary record. While the majority reconciles the record by prioritizing the functional vocational impact, viewing Dr. Vally's analysis as the essential clinical

link between industrial medication and permanent total disability, I view this approach as a departure from established medical-legal procedure. Because Dr. Vally operated outside the primary treating physician framework and lacked a contemporaneous physical examination, his report fails to meet the evidentiary standards required to supplant the coordinated, multi-specialty evaluations of the appointed QMEs.

Crucially, it is impermissible to ignore the breadth of the overwhelming medical evidence regarding permanent disability by focusing exclusively on Dr. Vally's procedurally defective reporting and Mr. Largo's flawed vocational synthesis. The evidentiary record contains exhaustive, multi-specialty evaluations from four separate QMEs, Dr. Luciano, Dr. Lineback, Dr. Agatstein, and Dr. Tang. Together, they conducted multiple in-person examinations, administered objective diagnostic testing, and formulated computationally detailed impairment ratings across orthopedic, internal, urological, and psychiatric systems that culminated in 89% permanent disability. To disregard this comprehensive body of coordinated medical evidence in favor of an isolated, unexamined secondary medical report actively subverts the statutory framework of medical-legal evaluations. Substantial evidence requires evaluating the record as a whole. It does not permit a WCJ to cherry-pick a fragmented opinion to justify a 100% permanent disability award while discarding the overwhelming consensus of the QMEs.

Accordingly, for all the foregoing reasons, I dissent.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

OCTOBER 8, 2026

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

JUAN ALEGRIA
MAURICE L. ABARR-LAWYER, INC.
GUILFORD SARVAS & CARBONARA LLP

DLP/md

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