WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

LESSIE WILLIAMS, *Applicant*

vs.

SUBSEQUENT INJURIES BENEFITS TRUST FUND, *Defendant*

Adjudication Numbers: ADJ1104751 (VNO 0515079) (MF); ADJ2006794 (VNO 0515077); ADJ2723378 (POM 0267044)
Van Nuys District Office

OPINION AND DECISION AFTER RECONSIDERATION

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

Applicant seeks reconsideration of the Joint Findings of Fact & Order (F&O) issued on November 17, 2022, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant, while employed as a paraeducator/teacher's assistant during the period from October 1, 1978 to March 31, 2003, sustained industrial injury to her back and knees (ADJ1104751), on February 2, 1987 to her right knee (ADJ2006794), and on May 18, 2001 to her left knee (ADJ2723378); and that she was not entitled to Subsequent Injuries Benefits Trust Fund (SIBTF) benefits.

Applicant claims that she met the minimum subsequent compensable and preexisting labor disabling permanent disability threshold under Labor Code section 4751[1] to merit entitlement to SIBTF benefits.

We did not receive an Answer from defendant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending we deny reconsideration.

We have considered the allegations in the Petition, and the contents of the WCJ's Report with respect thereto. Based on our review of the record and the reasons discussed below, as our Decision After Reconsideration, we will rescind the F&O and substitute a new F&O finding that applicant's SIBTF claim is not time-barred and deferring all other issues.

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

BACKGROUND

Applicant, while employed as a paraeducator/teacher's assistant for the Los Angeles County Office of Education (LACOE), sustained the following industrial injuries:

- On February 2, 1987 to her right knee (ADJ2006794);
- On May 18, 2001 to her left knee (ADJ2723378); and
- During the period October 1, 1978 to March 31, 2003 to her back and knees (ADJ1104751)

In his report dated June 13, 2011, Agreed Medical Evaluator (AME) Roger S. Sohn, M.D., after evaluating applicant, took a history that applicant sustained distinct work-related injuries between 1984 and 2001 while performing her usual duties, yet she maintained her employment throughout each recovery. During the period from October 1, 1978 to January 16, 2003, and beginning on February 29, 1984, she injured her back after tumbling down a stairway while attempting to restrain a rushing student. On February 2, 1987, she suffered a right knee injury after stepping onto a curb, which eventually necessitated an arthroscopic surgery in 1997 that left her with chronic pain and limited mobility. Finally, on May 18, 2001, a student's chair struck her left knee, causing immediate swelling and an antalgic gait. (Court Ex. Z2, pp. 2-3.)

With respect to permanent disability, AME Dr. Sohn concluded that applicant was unable to compete in the open labor market (*Id.* at p. 11). For the lumbar spine, AME Dr. Sohn assigned 12% whole person impairment (WPI) under DRE Lumbar Category III pursuant to Table 15-3 on page 384 of the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides). However, he departed from the DRE method and, citing *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc) (*Almaraz/Guzman II*), analogized to Figure 15-19, which provides 90% WPI for complete loss of lumbar spinal function, and opined that a 50% loss of lumbar capacity equated to 45% WPI. He supported the analogy merely stating that "[s]he has severe loss of motion and spasm." For the knees, he assigned 30% WPI to each knee under Table 17-33 on page 547 of the AMA Guides but further determined that, due to applicant's need for routine use of a walker, equivalent to two canes or two crutches under Table 17-5(g) on page 529 of the AMA Guides, each knee warranted 40% WPI. He combined the bilateral knee impairment to 64% WPI and then combined that value with the lumbar spine impairment of 45% WPI, resulting in 80% WPI. (*Id.* at pp. 11–12.)

With respect to apportionment, AME Dr. Sohn apportioned, after his correction in his supplemental report dated August 31, 2011, for the lumbar spine, 50% to the October 1, 1978 to March 31, 2003 injury and 50% to underlying degenerative disease. He apportioned as follows: for the right knee, 25% to the February 2, 1987 injury, 50% to the October 1, 1978 to March 31, 2003 injury and 30% to underlying degenerative disease; and for the left knee, 20% to the May 18, 2001 injury, 50% to the October 1, 1978 to March 31, 2003 injury and 30% to underlying degenerative disease. (*Id.* at pp. 12-13, Court Ex. X-2, p.1.)

In his December 6, 2012 deposition, AME Dr. Sohn testified that applicant's severe, chronic back pain following a failed laminectomy is the primary cause of her profound impairment, asserting that her spinal condition alone justifies a total permanent disability rating, independent of her knee injuries. (Court Ex. Z3, pp. 7:18-25 to 8:1, 34:25 to 35:1-7.) While he acknowledged her bilateral knee conditions would individually restrict her to sedentary work, he maintained that she cannot reliably sustain even an at-home or part-time job due to her overall condition (*Id.* at pp. 17:15-25 to 20:1-2, 35:5-7.) Because he considered her situation a "complex or extraordinary" case involving a "horrific condition," AME Dr. Sohn utilized an *Almaraz/Guzman II* analysis rather than strictly following the standard AMA Guides, which he argues fail to properly account for her severe pain and actual work restrictions. (*Id.* at pp. 20:11-15 to 23:1-22.) To reflect accurately her true impairment, he applied a functional loss methodology, assigning a 90% impairment to the lumbar spine and 40% to the lower extremities (*Id.* at p. 24:7-9.)

In his report dated August 29, 2011, AME Paul J. Grodan, M.D., after evaluating applicant, diagnosed her with industrially caused hypertension with associated renal insufficiency. AME Dr. Grodan restricted her from undue emotional stress and very heavy lifting. (Court Ex. X1, p. 46.) In addition, AME Dr. Grodan assessed 15% WPI based on Class 2 under Table 4-2 on page 66 of the AMA Guides, due to diastolic dysfunction of the left ventricle and 40% WPI based on Class 3 under Table 7-1 on page 146 of the AMA Guides, due to a glomerular filtration rate of 34. (*Id.* at pp. 45-46.) With respect to apportionment, applying *Benson v. Permanente Med. Group* (2007) 72 Cal.Comp.Cases 1620, 1622 (Appeals Board en banc), he deemed her cardiovascular condition inextricably intertwined with her 12 industrial injuries and was entirely industrial in origin. (*Id.* at pp. 44-45.)

In his supplemental report dated August 29, 2011, AME Dr. Grodan explained that applicant's cardiovascular disability, principally longstanding hypertension, cannot be separated

among her multiple injuries because it developed and worsened over time as a cumulative consequence of her numerous specific and continuous industrial orthopedic injuries. (Court Ex. X1, p. 3.) AME Dr. Grodan noted that chronic pain, repeated trauma, poor surgical outcomes, reduced mobility, emotional stress, and substantial weight gain resulting from those injuries materially aggravated her hypertension and overall cardiovascular status. Because these factors operated together over many years, he concluded their effects were "inextricably intertwined," making it impossible to apportion the condition to individual injuries or time periods without speculation. (*Id.* at pp. 3-4.) He further reasoned that asymptomatic nonindustrial degenerative disease did not drive her inactivity or weight gain and therefore did not materially contribute to the cardiovascular impairment, leading him to attribute the disability entirely to the industrial injury history. (*Id.* at p. 4.)

In his July 24, 2014 deposition, AME Dr. Grodan testified that applicant's hypertension related permanent disability developed progressively over time preventing precise separation among multiple injury periods, describing its impact as a continuous "continuum" rather than discrete events. (Court Ex. X2, pp. 16:22-25 to 17:1-8, 19:3-15.)

In his report dated July 19, 2011, AME Carl E. Marusak, M.D., after evaluating applicant, diagnosed her with a Depressive Disorder Not Otherwise Specified, attributed it predominantly to her orthopedic condition, assigned a Global Assessment of Functioning (GAF) of 63 or 11% WPI and apportioned 70% to the October 1, 1978 to March 31, 2003 with 30% to nonindustrial factors. (Court Ex. Y1, pp. 24-25, 28-30.)

In his September 8, 2014 deposition, AME Dr. Marusak testified that applicant's permanent psychiatric disability largely stemmed from chronic pain, functional loss, and reduced mobility caused by her orthopedic injuries, and he apportioned that disability primarily to industrial cumulative trauma rather than to isolated events. (Court Ex. Y2, pp. 8:1-25 to 10:1-2, 14:1-25 to 15:1-10.) He explained that, in his view, the most compelling cause was long-standing degeneration and osteoarthritis from repetitive injury, making precise allocation to specific incidents difficult (*Id.* at pp. 14:20-25 to 15:1-10). Ultimately, he apportioned 7.5% to the February 2, 1987 injury, 7.5% to the May 18, 2001 injury, 55% to the October 1, 1978 to March 31, 2003 injury and 30% to nonindustrial factors. (*Id.* at pp. 14:12-25 to 1-10.)

On March 9, 2018, applicant resolved her workers' compensation case-in-chief by way of a Compromise & Release (C&R) for $400,000.00. (App. Ex. 6.)

Applicant filed a timely application for SIBTF benefits dated September 5, 2011. (App. Ex. 11.)

On September 22, 2022, the parties appeared for trial seeking adjudication of applicant's entitlement to SIBTF benefits.

Applicant submitted into evidence the Qualified Medical Evaluation (QME) reports of Steven Scribner, D.C. (App. Exs. 9-10), Richard N. Shaw, M.D. (App. Ex. 7), and Sean Sterling, Ph.D. (App. Ex. 8), as well as the vocational expert reports of Susan Green, M.S. (App. Exs. 1, 3). Defendant submitted into evidence the QME report of Richard Byrne, M.D., dated April 15, 2022. (SIBTF's Ex. P.)

In his report dated June 1, 2019, QME Dr. Scribner, after evaluating applicant, took a history that she sustained numerous workplace injuries while employed by the LACOE from 1978 to 2004. A series of knee injuries, including incidents in which students struck her knees with chairs, progressively worsened her condition and ultimately required a total right knee replacement, after which Dr. Garfinkel removed her from work. She retired in August 2005. She now uses an electronic scooter and a wheeled walker as needed. She also developed hypertension after experiencing lightheadedness and dizziness. Her physician detected elevated blood pressure during evaluation and started her on medication, which she continues to take. In September 2000, she filed a claim for chest pain and heart-related conditions, and she remains unaware of its resolution. (App. Ex. 9, pp. 3-4.) Prior to her October 1, 1978 to March 31, 2003 injury, she states that her symptoms and impairments limited her ability to walk, sit, squat, lift, push, pull, climb, reach, stoop, hike, and perform many other activities of daily living, and she restricted herself to light work as a result of these limitations. (*Id.* at p. 4.)

With respect to permanent disability, QME Dr. Scribner agreed with AMEs Dr. Sohn, Dr. Grodan, and Dr. Marusak, finding 91% WPI. (*Id.* at p. 59.) QME Dr. Scribner stated as follows:

> Mrs. Williams was seen by Dr. Roger Sohn for AME for the orthopedic component of the subsequent injuries on June 13, 2011. She was awarded a total 80% WPI for her injuries to her lumbar spine and bilateral knees. Mrs. Williams was then evaluated by Dr. Paul Grodan on August 29, 2011 for AME for internal medicine injuries and she was awarded 15% WPI for her diastolic dysfunction and 40% WPI for her upper urinary tract disease. She also saw Dr. Carl Marusak for psychological evaluation, and she was awarded an 11% WPI for psychological impairment. No other SI impairments were addressed.

(*Id.* at p. 4.)

QME Dr. Scribner's medical record review outlined a comprehensive preexisting medical history for applicant. Prior to March 31, 2003, applicant's medical records documented a longstanding history of preexisting conditions, beginning with psychological issues described as a "phobia-fear of things" in 1963 and pulmonary problems that she reported experiencing since the 1970s. (*Id.* at pp. 49, 51.) Her surgical history before this date included a complete hysterectomy performed in 1999 for suspected endometriosis. (*Ibid.*) She developed hypertension in approximately 1998 and filed a related claim for chest pain and heart conditions in September 2000. (*Id.* at pp. 5, 15.) On April 1, 2003, Jay Brown, M.D., noted in an emergency department report that applicant took Lipitor to manage her cholesterol. (*Id.* at p. 5.)

Applicant suffers from a preexisting sleep and arousal disorder. QME Dr. Scribner found applicant has a sleep and arousal disorder that predated her later injuries and causes reduced daytime alertness, which interferes with some activities of daily living (ADLs) and limits her ability to work safely, particularly in physically demanding or driving occupations. QME Dr. Scribner assigns her 21% whole person impairment (WPI) based on Class 2 under Table 13-4 on page 317 of the AMA Guides, and recommended a sleep study. (*Id.* at p. 60.)

Applicant underwent a hysterectomy in 1999. QME Dr. Scribner found no labor disabling impairment but assigned her 11% WPI based on Class 1 under Table 7-10 on page 165 of the AMA Guides. (*Ibid.*)

Applicant suffers from preexisting hypothyroidism, causing symptoms such as lethargy, slowed mental processing, weakness, cold intolerance, and occasional dry skin, with myocardial insufficiency as a potential late effect. QME Dr. Scribner assigned 10% WPI based on Class 1 under Table 10-2 on page 218 of the AMA Guides because she requires ongoing therapy to maintain normal thyroid function. (*Id.* at p. 61.)

Applicant suffers from preexisting hyperparathyroidism with complications including stage 3 renal failure. QME Dr. Scribner assigned 12% WPI under Table 10-3 on page 219 of the AMA Guides because her symptoms respond well to medical therapy. (*Ibid.*)

Finally, applicant suffers from preexisting osteoporosis meriting an additional 8% WPI based on Chapter 10.10c on pages 240 to 241 of the AMA Guides due to her long standing hysterectomy. (*Id.* at pp. 61-62.)

In his report dated September 23, 2019, QME Dr. Shaw, after evaluating applicant, stated that she reported taking gabapentin 400 mg twice daily to manage chronic back pain following two

surgeries. She takes atorvastatin 40 mg daily for hypercholesterolemia at a stable dose since the mid-1990s. For longstanding hypertension, she takes metoprolol 100 mg twice daily, losartan 50 mg twice daily, and nifedipine XL 30 mg twice daily. She also takes omeprazole daily for mild hyperacidity and GERD, thyroid hormone replacement 0.25 mg daily, and alendronate 70 mg weekly for osteoporosis. In addition, she uses tramadol 50 mg up to three times daily as needed for pain and takes omega krill oil. (App. Ex. 7, p. 2.)

When she left her job in 2003, she weighed about 260 pounds after previously losing significant weight from gastric bypass surgery but later regaining much of it. She had weighed about 180 pounds when she began working and currently weighs about 330 pounds. She reports longstanding hypercholesterolemia treated with atorvastatin since 1995 without side effects, hypertension treated since the early 1990s, and stable irregular heartbeats. She has a long history of allergies and upper respiratory problems that progressed to mild-to-moderate asthma, aggravated by obesity, with shortness of breath requiring inhalers and associated with reduced oxygen saturation, and her physician recommends further pulmonary evaluation although she cannot lie flat for CT imaging. She also reports long-term antihistamine use, possible prior pulmonary testing with unknown results, and cardiology care. Functionally, she has relied on a walker since 2006 and a power wheelchair since 2012, uses the wheelchair outside the home, and ambulates short distances indoors by holding onto furniture. (*Id.* at pp. 3-4.)

Based on QME Dr. Shaw's record review, prior to 2003, applicant's medical records reveal a complex history of preexisting conditions, most prominently a longstanding struggle with severe obesity. Records indicate she weighed 223.5 pounds as early as 1985 and approximately 260 pounds by the time she stopped working in 2003, having previously undergone and regained weight following gastric bypass surgery. (*Id.* at pp. 3, 65.) This chronic obesity served as a foundational aggravating factor for her sleep and arousal issues. QME Dr. Shaw strongly suspected undiagnosed sleep apnea driven by her historical weight. (*Id.* at pp. 8-9.) These early conditions also affected her metabolic and cardiovascular systems, as she has managed her hypercholesterolemia with a stable medication dose since 1995. (*Id.* at pp. 2-3.) Her pulmonary history includes a preexisting pattern of upper respiratory congestion, allergies, and asthma requiring inhalers that traces back "many, many years" alongside historical antihistamine use. (*Id.* at p. 3.) Furthermore, she developed early signs of chronic renal failure around 1999, noted as 20 years prior to the 2019 exam, which laid the groundwork for associated conditions such as secondary hyperparathyroidism and osteoporosis noted

extensively in her chart. (*Id.* at pp. 6, 13, 80.) Although the medical record lacks explicit onset dates for her hypothyroidism and hysterectomy, these records clearly establish both as preexisting factors by her 2004 hospitalizations. (*Id.* at pp. 4, 6, 24.)

PQME Dr. Shaw identified a longstanding history of metabolic and cardiovascular disorders that predate the industrial injuries, tracing these issues back to the 1980s and 1990s. He utilized the Body Mass Index (BMI) as a primary diagnostic tool, noting that an initial BMI of 26.1 in the late 1970s already signaled an early risk for hypercholesterolemia and peripheral vascular disease. As the BMI climbed to 37.75 by 2003 and eventually 47.4, these metabolic disorders accelerated the advancement of hypertensive cardiovascular disease, resulting in end-organ damage such as cardiac enlargement and mild renal dysfunction. PQME Dr. Shaw classified the impairment between 30-49% WPI based on Class 3 under Table 4-2 on page 66 in the AMA Guides, citing the reliance on multiple medications and evidence of left ventricular thickening. (*Id.* at pp. 111-113.)

In his report dated July 21, 2019, PQME Dr. Sterling, after evaluating applicant, diagnosed her with a preexisting, labor-disabling Adjustment Disorder with Mixed Anxiety and Depressed Mood. (App. Ex. 8, p. 62.) This condition originated from the sudden death of her four-year-old sister in 1962, for whom 15-year-old applicant was the primary caregiver. (*Id.* at pp. 4-5.) The traumatic loss caused severe emotional sequelae, including intense guilt, crying spells, nightmares, irritability, and an inability to concentrate in school. (*Id.* at pp. 60-61.) This unresolved grief directly impaired her occupational functioning. Specifically, she quit her first job as a nurse's aide in a convalescent hospital at age 17 or 18 because interacting with severely ill patients triggered painful reminders of her sister's passing. (*Id.* at pp. 8, 61.) Because her emotional vulnerability, fatigue, and preoccupation with her sister's death made it difficult for her to face serious physical illnesses with equanimity, QME Dr. Sterling concluded this condition was genuinely labor disabling and had reached maximum medical improvement by 1967. (*Id.* at p. 62.) He determined she has a GAF score of 63 or 11% WPI.

In his supplemental report dated November 12, 2019, QME Dr. Scribner stated as follows:

> I agree with the findings of Dr. Shaw and his impairment ratings. ***Dr. Shaw assigned a range of 30%-49% WPI for the constellation of her internal medicine impairments. I will assign her at the high end of the rating at 45% WPI*** due to the impact that her internal medicine injuries have on her abilities to perform her normal ADLs. Her internal medicine impairments are highly labor disabling. She really cannot engage in any occupation at this point including sedentary work. For obvious reasons, she cannot perform any physical work as she is confined to an electronic scooter (wheelchair) for 90% of her waking hours. She is by any and all standards 100% disabled. She should not engage in any occupation or activities that may

> increase her blood pressure or get her excited in any way as this may exacerbate, her internal medical conditions to the point of catastrophic.

(App. Ex. 10, p. 4, emphasis added.)

QME Dr. Scribner added the 45% WPI to applicant's preexisting hypercholesterolemia, obesity and pulmonary impairment as well as QME Dr. Sterling's 11% WPI to applicant's preexisting psychological impairment. (*Id.* at pp. 5-8.)

In her report dated December 5, 2012, VE Ms. Green conducted an in-home interview and follow-up contacts. (App. Ex. 1, pp. 1-2.) She reviewed applicant's educational background and 25-year work history as a Teacher's Aide with LACOE (Id. at pp. 2–3). She also evaluated applicant's functional limitations, including reliance on a walker and power wheelchair, the need to elevate her legs, severely limited tolerance for sitting, standing, and walking, chronic pain, medication side effects, sleep disturbance, and psychiatric symptoms. (Id. at pp. 2, 6, 8.) VE Ms. Green applied computerized vocational testing and labor-market/transferable-skills analyses using MVQS and DOT classifications (*Id.* at pp. 7-9), adjusting applicant's profile to reflect medically documented restrictions that reduced her functional capacity to less than sedentary levels. The analyses showed that, although her pre-injury work potentially accessed numerous jobs, her current limitations eliminate viable occupational alternatives and leave her with no transferable skills and 0% residual employability. (*Id.* at p. 8.) VE Ms. Green also considered applicant's limited formal education, single-occupation work history, prior unsuccessful return-to-work efforts, and ongoing need for frequent medical care. (*Id.* at pp. 7–8.) Based on the totality of the medical evidence, vocational testing, occupational history, and observed limitations, VE Ms. Green concluded that applicant cannot reasonably compete in the open labor market, cannot sustain regular employment, and is not a feasible candidate for retraining or vocational rehabilitation. (*Id.* at pp. 8–9.)

At the trial on September 27, 2022, applicant testified in relevant part as follows: She began working as a teacher's assistant for the LACOE in 1978 and experienced her first knee injury in 1987, ultimately undergoing four right knee surgeries and one left knee surgery in 2003. She developed back problems in 2008, leading to surgery in 2010, and saw multiple doctors, including AME Dr. Sohn and QMEs Drs. Scribner, Sterling, and Shaw, providing accurate medical histories. (Minutes of Hearing / Summary of Evidence (MOH/SOE) 09/27/2022 6:13-21.) Before her employment with LACOE, she had high blood pressure, hypothyroidism, high cholesterol, kidney issues, and psychiatric concerns dating back to her teens, including PTSD and depression following her sister's death. (MOH/SOE, 09/27/2022, 6:22-24 to 7:1-8.) She received State Disability

Insurance and disability checks from Liberty Mutual Insurance Company. She retired receiving CalPERS in 2005, though she does not consider it disability retirement. (MOH/SOE, 09/27/2022, 7:12-22.) She sustained two notable knee injuries while working, one from a chair and one from a student, but returned to work with restrictions. (MOH/SOE, 09/27/2022, 7:22-25 to 8:1-7.) Currently, she takes eight medications for cholesterol and blood pressure, has no diabetes or migraines, and previously filed only one personal injury claim in the early 1970s after a Gemco counter fell on her foot. (MOH/SOE, 09/27/2022, 7:7-10, 12-13.)

On November 17, 2022, the WCJ issued his Joint F&O, finding applicant failed to establish her eligibility for SIBTF benefits. In his Opinion on Decision, the WCJ stated that, while the claim for benefits was not time-barred, there was insufficient evidentiary and testimonial evidence that there was any preexisting labor disabling conditions. (Opinion, pp. 5-6.)

It is from this Joint F&O that applicant seeks reconsideration.

DISCUSSION

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

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

The key requirement of section 4751 is that an employee must demonstrate permanent partial disability before sustaining a subsequent industrial injury. (*Ferguson*, *supra*, 50 Cal.2d at p. 479; *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 619.)

Permanent disability is disability that causes permanent impairment of earning capacity or normal use of a member, or a competitive handicap in the open labor market. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320 [72 Cal.Comp.Cases 565]; *Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App.3d 224, 237 [43 Cal. Comp. Cases 310].) Permanent disability also includes impairment that causes loss of function of the body in whole or part. (Lab. Code, § 4751; *Franklin*, *supra*, 79 Cal.App.3d at p. 239) When determining permanent or total disability percentages, medical evaluators consider the nature of the physical injury or disfigurement, including the descriptions, measurements, and corresponding impairment percentages outlined in the AMA Guides. (Lab. Code, § 4660.)

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

While the AMA Guides function as advisory frameworks, they are not strict texts subject to rote or literal application. Instead, an evaluating physician may use their experience and expertise to interpret and apply any portion of the entire AMA Guides. Pursuant to *Almaraz/Guzman II*, the Appeals Board held that:

> [W]hile the AMA Guides often sets forth an analytical framework and methods for a physician in assessing WPI, the Guides do not relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment. Instead, the AMA Guides expressly contemplates that a physician will use his or her judgment, experience, training, and skill in assessing WPI.

(*Almaraz/Guzman II*, *supra*, 74 Cal.Comp.Cases. at pp. 1103-1104; affirmed by *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837] (*Guzman III*).)

The overarching goal of rating permanent impairment is to achieve accuracy (*Guzman III*, *supra*, 187 Cal.App.4th at p. 822) and the standard for calculating WPI is to determine the most accurate reflection of impairment as measured by any chart, table, or methodology contained within the entire AMA Guides. Thus, the proper application of *Almaraz/Guzman II* requires a physician to provide a

strict AMA Guides rating, explain why that strict rating does not accurately reflect the injured employee's functional limitations, and, with reasoned explanation, support an alternative rating derived from within the AMA Guides that more accurately reflects the employee's level of disability. (*Id.* at p. 828-829; *Leiva v. Webcor Construction* [2025 Cal. Wrk. Comp. P.D. LEXIS 390, *29-30]; *Linstad v. City of Richmond* [2025 Cal. Wrk. Comp. P.D. LEXIS 5, *9]; *Martin v. Cox Castle & Nicholson, LLP* [2024 Cal. Wrk. Comp. P.D. LEXIS 212, *17]; *Kelley v. Lawrence Berkeley National Laboratory* [2024 Cal. Wrk. Comp. P.D. LEXIS 115, *11].)[2]

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

The 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*, *supra*, 70 Cal.Comp.Cases at p. 621.) Medical or vocational reports and opinions do not constitute substantial evidence when they contain known errors or rely on facts that are no longer germane, inadequate medical histories or examinations, or incorrect legal theories. Likewise, a medical or vocational opinion cannot support the Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].) Accordingly, the Board may reweigh the evidence and reach a decision different from the WCJ's determination when

[2] 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.

other evidence of substantial probative value supports a contrary conclusion. (*Lamb*, *supra*, 11 Cal.3d at p. 281 [39 Cal.Comp.Cases 310]; *Garza*, *supra*, 3 Cal.2d at pp. 318-319.)

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

However, a retroactive prophylactic work restriction determined after the industrial injury does not establish permanent disability or impairment before the injury unless substantial evidence demonstrates that the employee had work restrictions beforehand. (*Franklin*, *supra*, 79 Cal.App.3d at p. 238; *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 619.) Such evidence may include an actual prophylactic work restriction before the industrial injury. (*Franklin*, *supra*, 79 Cal.App.3d at p. 238.) Applying a retroactive prophylactic work restriction which is not supported by substantial evidence creates a factual or legal fiction of an otherwise nonexistent previously disability or physical impairment. (*Ibid.*) Instead, there must be substantial medical evidence establishing permanent disability or impairment independent of any retroactive prophylactic work restrictions. (*Allen*, *supra*, 56 Cal.2d at p. 846; *Franklin*, *supra*, 79 Cal.App.3d at p. 391.)

Here, the evidentiary record demonstrates substantial and documented preexisting impairment. For example, QME Dr. Sterling diagnosed a preexisting Adjustment Disorder stemming from a 1962 trauma that reached maximum medical improvement by 1967 and directly impaired her occupational functioning, causing her to quit a job as a nurse's aide. Additionally, QMEs Dr. Shaw and Dr. Scribner reviewed extensive medical records documenting a longstanding history of metabolic, cardiovascular, and pulmonary disorders, including severe obesity, hypercholesterolemia treated since 1995, and hypertension dating to the early 1990s, all of which predated her departure from work in 2005. Furthermore, applicant credibly testified at trial that she suffered from high blood

pressure, hypothyroidism, high cholesterol, kidney issues, and psychiatric concerns well before her employment with LACOE even began in 1978. Because the QMEs based their comprehensive evaluations firmly on historical medical records and applicant's corroborating testimony rather than on mere speculation, she has successfully established some preexisting, labor disabling conditions. Therefore, upon remand, the WCJ will need to calculate applicant's WPI based on the parts of body with documented preexisting labor disabling conditions.

In addition, AME Dr. Sohn's permanent disability evaluation fails to constitute substantial medical evidence because he explicitly abandons the mandatory, objective protocols of the AMA Guides in favor of unsupported categorizations. Regarding the lumbar spine, AME Dr. Sohn assigns 12% WPI under DRE Lumbar Category III. However, his own clinical examination directly contradicts the criteria for this category by documenting negative bilateral straight leg raising tests, symmetric deep tendon reflexes, and entirely normal lower extremity sensory findings, thereby failing to establish the requisite objective evidence of radiculopathy. In the absence of a properly supported standard rating under the AMA Guides, it is premature to apply *Almaraz/Guzman II* to support an analogous WPI approach multiplying a subjective 50% loss of overall lumbar capacity against the 90% maximum impairment delineated in Figure 15-19 for complete spinal functional loss.

Similarly, the bilateral knee evaluation lacks legal sufficiency. AME Dr. Sohn summarily concluded the total knee arthroplasties represent a "poor result" warranting 30% WPI per knee under Table 17-33 without performing the prerequisite point-based calculations for pain, range of motion, stability, and alignment required to substantiate that classification. He subsequently abandoned this unsupported rating entirely, improperly pivoting to Table 17-5(g) to extract 40% WPI per knee based exclusively on applicant's use of a walker. Because Dr. Sohn failed to articulate any clinical rationale explaining how the walker usage independently satisfies the rigorous functional criteria of Table 17-5 or why it justified overriding the specific joint replacement protocols of Table 17-33, his ultimate impairment conclusions lack the indispensable analytical integrity necessary to support a judicial finding of permanent disability. Accordingly, because AME Dr. Sohn's WPI rating does not comply with the AMA Guides, his opinion does not constitute substantial medical evidence.

We also find problematic QME Dr. Scribner's attempt, in his analysis, to exact a 45% WPI rating from QME Dr. Shaw's 30-49% WPI for the hypertensive cardiovascular disease, a determination that traverses outside of QME Dr. Scribner's expertise in chiropractic medicine.

In addition, given that we found AME Dr. Sohn's opinion on permanent disability not substantial medicine evidence, we are unable to rely on QME Dr. Scribner's mere adoption of the opinion as his own substantial medical evidence. Finally, his chiropractic assessment of permanent disability for the hypothyroidism, hyperparathyroidism and osteoporosis, conditions more suited for opinion by a physician skilled in internal medicine, cannot form the basis of reliable medical evidence for a judicial determination of preexisting labor disabling permanent disability.

"[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 further 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] (*Tyler*); *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.)

Accordingly, upon remand, we recommend that QMEs Dr. Scribner and Dr. Shaw perform reevaluations and provide independently determined permanent disability opinions for conditions within their expertise.

In addition, while we express no opinion on AME Dr. Grodan's determination that applicant's 12 industrial injuries are "inextricably intertwined," we would suggest AME Dr. Grodan issue a supplemental report reconciling his opinion with the other reporting physicians whose opinions on apportionment limit the permanent disability to 3 of the 12 injuries.

Accordingly, we rescind the F&O and substitute a new F&O finding that applicant's SIBTF claim is not time-barred and is deferred.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings & Award dated November 17, 2022 is **RESCINDED** and the following is **SUBSTITUTED** therefor:

FINDINGS OF FACT

1. Lessie Williams, while employed during the period October 1, 1978 to March 31, 2003, as a paraeducator/teacher's assistant, Occupational Group No. 214, at Los Angeles, California, by L.A. County Department of Education, sustained injury arising out of and in the course of employment to her back and knees.

2. Lessie Williams, while employed on February 2, 1987, as a paraeducator/teacher's assistant, Occupational Group No. 214, at Los Angeles, California, by L.A. County Department of Education, sustained injury arising out of and in the course of employment to her back and knees.

3. Lessie Williams, while employed on May 18, 2001, as a paraeducator/teacher's assistant, Occupational Group No. 214, at Los Angeles, California, by L.A. County Department of Education, sustained injury arising out of and in the course of employment to her back and knees.

4. Applicant's claim for Subsequent Injuries Benefits Trust Fund benefits is not time-barred.

5. All other issues are deferred.

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

July 17, 2026

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

LESSIE WILLIAMS
TERRELL FIRM
OFFICE OF THE DIRECTOR – LEGAL UNIT (LOS ANGELES)

DLP/md

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