

**WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA**

VIVIANA GREENE, *Applicant*

vs.

SUBSEQUENT INJURIES BENEFITS TRUST FUND, *Defendant*

**Adjudication Number: ADJ8387927
San Francisco 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

Applicant seeks reconsideration of the Findings of Fact & Award (F&A) issued on May 24, 2022, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant had a pre-existing asthma condition with 22% permanent disability and left ankle injury on July 23, 2009 with 3% permanent disability. When combined with the subsequent November 4, 2010 injury, caused 73% permanent disability, met the eligibility threshold for Subsequent Injuries Benefits Trust Fund (SIBTF) benefits, resulting in a combined permanent disability award of 98% less credit under Labor Code section 4753.²

Applicant contends that the medical evidence from Qualified Medical Evaluator (QME) Scott Anderson, M.D., as well as vocational expert (VE) evidence from Maria Brady, MS, demonstrated pre-existing permanent disability from allergic rhinitis, irritable bowel syndrome (IBS), gastroesophageal reflux disease (GERD) and dermatitis (in the form of a rash) resulting in a 100% permanent disability award.

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

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.

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

We have considered the allegations in the Petition and the Answer and the contents of the WCJ's Report. Based on our review of the record, and for the reasons discussed below as well as the WCJ's Report, which we adopt and incorporate, as our Decision After Reconsideration, we will affirm the WCJ's May 24, 2022 decision.

BACKGROUND

Applicant, while employed as health inspector on November 4, 2010, sustained an industrial injury to her lumbar spine, lower extremities and psyche resulting in a 73% permanent disability award. (Minutes of Hearing / Summary of Evidence (MOH/SOE), 02/09/2022, 2:6-10, 2:24-28.) In addition, due to a preexisting left ankle injury on July 23, 2009, applicant sustained 3% permanent disability. (MOH/SOE, 02/09/2022, 2:33-37.)

Applicant submitted into evidence the QME report of Dr. Anderson dated December 4, 2020. (App. Ex. 1.) In addition, applicant submitted Panel QME medical reports and deposition testimony of Babak Jamasbi, M.D., (App. Exs. 2, 21-23, 25), VE reports of Malcolm Brodzinsky, M.A., (App. Exs. 4-5), Richard Lieberman, M.D., (App. Exs. 8-10), Tracy Newkirk, M.D., (App. Exs. 11-14), Corey Bercun, Ph.D., (App. Ex. 15), Ruben Kalra, M.D., (App. Ex. 16), and Timothy Lo, M.D. (App. Ex. 20.)

In his report dated December 4, 2020, QME Dr. Anderson, after evaluating applicant, took a history that she functioned at a very high level before November 4, 2010, when a motor vehicle struck her and threw her onto the asphalt. She injured her upper and lower extremities and head. Although she extended her arm to brace herself and protect her head, she still sustained blunt force trauma. Since then, she experienced numerous physical problems that have made it difficult to return to work, many of them orthopedic. Over her lifetime, she underwent extensive treatment, including physical therapy, injections, surgery, pain management, and the use of braces, corsets, canes, crutches, a walker, neck and back supports, and orthotics. Diagnostic testing has included X-rays, MRI studies, and endoscopy. She continues to experience extremity pain, muscle cramps, muscle atrophy, and weakness in her arms and legs. Despite treatment with multiple medications, her condition had plateaued and had not meaningfully improved. (App. Ex. 1, pp. 4-5.)

She has longstanding vestibular dysfunction since she was 30 years old that has gradually worsened, causing instability, intermittent falls, and the need for ski poles when walking. Her physicians have not identified a precise cause, though they suspect chronic inner ear dysfunction. Symptoms were significant before the accident and worsened afterward, and she

continues medication. She has had GERD for 30 years with retrosternal burning treated with proton pump inhibitors (PPIs), without Barrett's esophagus or esophageal rupture, and reports some worsening after the accident. She has experienced IBS for 15 years, marked by abdominal cramping and alternating constipation and diarrhea, without ulcerative colitis or Crohn's disease. She has had asthma for 20 years, triggered by exhaust, pollen, dust, and debris, which developed after she moved from the Galapagos Islands of Ecuador to the United States about 30 years ago, with no history of inherited lung disease. She also has allergic rhinitis with seasonal flares, without chronic sinusitis or nasal malignancy. For about 20 years, she has had intermittent eczematous rashes treated with topical steroids and antihistamines. She developed fibromyalgia symptoms about 20 years ago, including nonrestorative sleep, cognitive fog, fatigue, and extremity pain, which significantly worsened after the accident. She has had migraine headaches for 25 years, sometimes preceded by visual aura, occurring about twice monthly and lasting four to six hours, without evidence of brain tumor. Since her November 4, 2010 injury, she has gained weight, which she attributes to reduced activity. She also has left ankle osteoarthritis from a prior injury that worsened after the accident, resulting in chronic pain and reduced range of motion without inflammatory arthritis. Together, these conditions limit her ability to bend, stoop, climb, lift, twist, or walk on uneven ground. She remains compliant with her medications and follows regularly with her physicians. (*Id.* at pp. 5-7.)

From 2007 to 2009, applicant received ongoing care for allergic rhinitis, IBS, GERD and chronic dermatitis from several physicians at Kaiser Permanente. Timothy M. Deneau, D.O., oversaw applicant's pre-placement physical on September 28, 2007 and found her fit for duty with controlled asthma and normal spirometry. Teresa M. Caron, M.D., addressed applicant's chronic gastrointestinal issues, including diarrhea and dyspepsia, and guided adjustments to her asthma medications to reduce her persistent acneform rash. Jessica A. Keane, M.D., monitored applicant's asthma, abdominal discomfort, and weight changes, recommending pulmonary function tests, peak flow monitoring, PPIs for GERD, and trials of QVAR (beclomethasone dipropionate) and other inhalers for symptom control. Laura W. Eberhard, M.D., managed ongoing asthma exacerbations, chronic cough, postnasal drip, and dermatitis, providing courses of prednisone, inhalers, antibiotics, and topical treatments. Daniel A. Smith, M.D., performed imaging and evaluation for abdominal and chest pain related to IBS and GERD, and coordinated care for dermatitis. Susan H. Gross, M.D., addressed acute asthma flare-ups, sinus symptoms,

costochondritis, and GERD, prescribing inhalers, antibiotics, and over-the-counter medications. Sonia I. Rapko, M.D., and Prasad A. Murthy, M.D., provided imaging support for sinus and gastrointestinal evaluations. Under the guidance of these physicians, they managed applicant's allergic rhinitis with inhalers and environmental controls, IBS caused persistent abdominal symptoms with limited response to H. pylori therapy, GERD produced retrosternal burning managed with PPIs and dietary modifications, and chronic dermatitis manifested as persistent acneform rashes and intercostal macular eruptions, managed with topical corticosteroids and systemic therapies. (*Id.* at pp. 8-15.)

QME Dr. Anderson opined, under the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), with respect to applicant's vestibular dysfunction, she had 18% whole person impairment (WPI). QME Dr. Anderson relied on Class 3 under Table 11-4 on page 253 of the AMA Guides because she has significant instability that has over the years required use of supportive devices. With respect to her GERD, she had 3% WPI based on Class 1 under Table 6-3 on page 121 of the AMA Guides. With respect to IBS, she had 8% WPI based on Class 1 under Table 6-4 on page 128 of the AMA Guides. With respect to asthma, she had 16% WPI based on a total asthma score of 3 under Table 5-10 on page 104 of the AMA Guides. With respect to allergic rhinitis, she had 3% WPI based on Class 3 under Table 11-6 on page 260 of the AMA Guides considering upper airway obstruction. With respect to chronic dermatitis, she had 3% WPI based on Class 1 under Table 8-2 on page 178 of the AMA Guides considering skin eruptions. With respect to fibromyalgia, she had 12% WPI based on Class 2 under Table 5-12 on page 107 of the AMA Guides due to decreased exercise capacity due to fibromyalgia at the lower end of Class II contemplating exercise between 5.7 and 7.1 METs. With respect to migraine headaches, she had 5% WPI based on Class 1 under Table 13-3 on page 312 of the AMA Guides considering periodic or episodic loss of consciousness or awareness. With respect to the left ankle, she had 3% WPI based on Table 17-11 considering a mild decrease in range of motion. (*Id.* at pp. 54-55.)

For work restrictions, before the 2010 injury, QME Dr. Anderson opined that applicant's pre-existing conditions required several practical work restrictions. Because of her vestibular dysfunction, she needed to avoid scaffolding and heights above three feet and have ready access to medications and fluids. Due to asthma and allergic rhinitis, she required a temperature controlled, air-conditioned environment free from significant dust exposure, along with access to

inhalers. Her GERD and IBS required convenient access to medications during the workday. Because of left ankle osteoarthritis, she needed disability parking and should avoid stair use. At that time, chronic dermatitis, fibromyalgia, migraine headaches, and obesity did not require specific work restrictions. (*Id.* at p. 56.)

With respect to apportionment, 40% of applicant's permanent disability is industrial with 60% due to non-industrial progression of degenerative or idiopathic process. (*Id.* at p. 55.)

QME Dr. Anderson concluded that, due to the number and complexity of her conditions, she would likely have missed one day of work per week for doctor's appointments even before her November 4, 2010 injury, limiting her ability to compete in the workplace. Currently, she cannot return to her previous employment and is effectively 100% permanently disabled and unemployable, as her multiple diagnoses across various specialties continue to impair her work capacity. (*Id.* at p. 57.)

In her report dated June 8, 2017, VE Ms. Brady, after evaluating applicant, concluded that she has a 73% Diminished Future Earning Capacity and is ultimately unlikely to maintain employment or succeed in vocational rehabilitation due to the combined severity of her industrial and non-industrial conditions. (App. Ex. 3, p. 14.) This determination is grounded in strict medical work restrictions that limit her to just four hours of simple, routine, sedentary work per day, requiring the use of a cane and regular leg elevation. (*Id.* at p. 7.) Vocational testing heavily supported this lack of capacity, revealing general reasoning scores in the 1st percentile and a 6.2 grade reading level, with the testing itself cut short because she physically could not endure the pain and dizziness it caused. (*Id.* at p. 6.), Finally, despite having a bachelor's degree, her biographical and cognitive limitations cement this conclusion. She has suffered a 100% loss of transferable occupational access due to her narrowly focused work history and experiences profound cognitive struggles, noting, "I can't read. I can't remember. I forget everything." (*Ibid.*)

On February 9, 2022, the parties proceeded to trial. They stipulated as follows:

1. Viviana Greene [], while employed on November 4, 2010, as a health inspector, Occupation Group Number 251, at Marin County, California, by the County of Marin, sustained injury arising out of and in the course of employment to the lumbar spine, lower extremities, and psyche, and claims to have sustained injury arising out of and in the course of employment to the brain, internal, and for headaches.

2. At the time of injury, the employee's earnings were \$1,365.38 per week, warranting indemnity rates of \$910.25 per week for temporary disability and \$230.00 per week for permanent disability.
3. Temporary disability was paid at the rate of \$910.25 2012 from November 11, 2010 to April 30, 2012. Thereafter, permanent disability began on May 1, 2012.
4. Parties stipulate that the subsequent injury for purposes of the claim for SIBTF benefits is the specific injury to the back, lower extremities, and psyche, of November 4, 2010, resulted in a 73% permanent disability award, with a permanent disability start date of May 1, 2012.
5. The Stipulations and Award for the injury of November 4, 2010, were issued September 6, 2019.
6. Parties stipulate that applicant meets the requirement for Subsequent Injuries Benefits Trust Fund benefits due to a preexisting ankle injury of July 23, 2009, for which a 3% whole person impairment was assigned and rated to 3% disability.
7. Parties stipulate that injuries the applicant alleges predated the industrial injury do not overlap with the industrial injury.
8. Parties stipulate that credit issues are deferred.

The issues they raised were as follows:

1. Parts of body injured, with the applicant claiming preexisting cognitive and internal disabilities from conditions including depression, vestibular dysfunction, gastroesophageal reflux disease (GERD), irritable bowel syndrome, asthma, allergic rhinitis, dermatitis, headaches, fibromyalgia, obesity, and the July 23, 2009 ankle injury.
2. Permanent disability, with the applicant asserting 100% permanent total disability, and SIBTF contending a total disability of 85.5%.

Applicant testified in pertinent part that, on November 4, 2010, she sustained an industrial injury when an automobile struck her left side while she was a pedestrian in a crosswalk. (MOH/SOE, 02/09/2022, 5:34-44.) She recalled being evaluated by PQME Dr. Jamasbi but does not remember any specific work restrictions and does not believe she can work four hours per day. She estimated she can lift no more than five pounds regularly and can only briefly lift, push, or pull up to ten pounds, such as while shopping. She uses two canes to walk and otherwise relies on a walker or wheelchair, occasionally using one cane if she can lean on a counter for support. She

cannot bend, stoop, crouch, crawl, use a ladder, or walk on uneven terrain. Although she can climb stairs, she must rest afterward and sometimes sit midway. Since the accident, she cannot walk up or down the hill where she lives. She can drive for only 20 to 30 minutes and can sit for about 20 minutes before severe hip and back pain forces her to stand. She must elevate her feet for ten minutes every two hours after sitting and typically lies in bed three or four times daily to do so. She takes one or two naps depending on her fatigue and cannot walk or stand for more than five minutes at a time. She also recalled being evaluated by Dr. Lieberman during a period of depression but does not remember a specific diagnosis. She reported memory loss, brain fog, difficulty recalling what she says, fatigue, poor sleep, and headaches for which she takes medication that sometimes causes her to sleep late into the morning. (MOH/SOE, 02/09/2022, 6:1-37.)

She experiences unpredictable dizziness and vertigo that interfere with her daily activities. Episodes can confine her to bed for an entire day. Her longest continuous episode lasted eleven days, about three to four years ago. (MOH/SOE, 02/09/2022, 8:3-8.)

She recalled QME Dr. Anderson evaluating her in 2020. She reported having vestibular dysfunction for 20 to 30 years, with treatment for asthma and rhinitis. She has suffered from rhinitis for 20 to 30 years and stated that her migraines began at least 20 years ago after she moved to the United States and gave birth to her daughter. She believed her fibromyalgia started around the same time. She has experienced GERD for 30 years following an H. pylori infection and suffers from IBS, alternating between constipation and diarrhea. She developed dermatitis approximately 20 years ago and has received treatment for all of these conditions, including treatment prior to her November 4, 2010 injury. (MOH/SOE, 02/09/2022, 7:6-19.)

Before her injury, applicant lived on a boat and enjoyed sailing, dancing a song or two, but not all night and without spinning, and walking to the beach. Although asthma kept her from being athletic, she remained moderately active as able. Her vestibular dysfunction did not stop her from going to the beach or hiking, but she avoided these activities during dizzy spells. She does not believe she can perform remote work due to difficulty concentrating and frequent medical appointments. She reported that her conditions cause tasks to take three to four times longer than usual. She does not recall any specific work restrictions before her November 4, 2010 injury. At that time, she relied on a cane due to a previous ankle injury, which had partially improved over the year preceding November 4, 2010, but had not fully healed. Before the November 4, 2010

injury, she progressed from a cane to a cast, then an air cast, and eventually hiking boots. (MOH/SOE, 02/09/2022, 9:6-33.)

On May 24, 2022, the WCJ issued his F&A, awarding 98% permanent disability, allowing only applicant's pre-existing asthma and left ankle disabilities in the calculation, less credit under section 4753.

It is from this F&A that applicant seeks reconsideration.

DISCUSSION

The SIBTF provides benefits to employees who establish that at the time of an industrial injury, they suffered from pre-existing permanent partial disability from a prior injury, which results in greater overall permanent disability than from the subsequent injury alone.

Section 4751 provides as follows:

If an employee who is permanently partially disabled receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70[%] or more of total, he shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury compensation for the remainder of the combined permanent disability existing after the last injury as provided in this article; provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg, or an eye, and the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such later permanent disability, when considered alone and without regard to, or adjust for, the occupation or age of the employee, is equal to 5[%] or more of total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35[%] or more of total.

The key requirement of section 4751 is that an injured worker must demonstrate permanent partial disability before sustaining a subsequent industrial injury. (*Ferguson v. Ind. Acc. Com.* (1958) 50 Cal.2d 469, 479 [23 Cal.Comp.Cases 108]; *Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 619 (Appeals Board en banc).)

Permanent disability is disability that causes permanent impairment of earning capacity or normal use of a member, or a competitive handicap in the open labor market. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320 [72 Cal.Comp.Cases 565]; *Franklin v. Workers' Comp. Appeals Bd.* (1978) 79 Cal.App.3d 224, 237 [43 Cal. Comp. Cases 310].)

Permanent disability also includes impairment that causes loss of function of the body in whole or part. (Lab. Code, § 4751; *Franklin, supra*, 79 Cal.App.3d at p. 239) When determining permanent or total disability percentages, medical evaluators consider the nature of the physical injury or disfigurement, including the descriptions, measurements, and corresponding impairment percentages outlined in the AMA Guides. (Lab. Code, § 4660.)

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

The employee and their employer are not required to know of the pre-existing permanent disability, impairment or underlying condition, nor must medical evidence of the permanent disability, impairment or underlying condition exist before the industrial injury. (*Subsequent Injuries Fund v. Ind. Acc. Com. (Allen)* (1961) 56 Cal.2d 842 [26 Cal. Comp. Cases 220] [Applicant eligible for benefits under section 4751 even though pre-existing hearing disability unknown and reported by otologists after industrial injury which increased disability]; *Franklin, supra*, 79 Cal.App.3d at p. 237 [The pre-existing permanent disability or impairment may be industrial or non-industrial, or arise from any source, developmental, pathological, or traumatic]; *Escobedo, supra*, 70 Cal.Comp.Cases at pp. 614-621 [Apportionment of permanent disability under SB 899 applies to pending litigation, including permanent disability which could not be previously apportioned such as a retroactive prophylactic work preclusion, if 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, based on the Kaiser Permanente medical records referenced in QME Dr. Anderson's report, there is no evidence that applicant's history of IBS, GERD, allergic rhinitis, and chronic dermatitis constituted a labor-disabling impairment prior to her industrial injury. While QME Dr. Anderson stated that these conditions existed for 15 to 30 years, the contemporaneous records, including a 2007 pre-placement physical by Dr. Deneau, expressly cleared applicant for "full duty" without any mention of these conditions as impediments. The documentation from Kaiser Permanente reflects standard medical management, such as symptom monitoring and medication adjustments, rather than any functional work restrictions or limitations. In addition, QME Dr. Anderson's retroactive work restrictions for applicant's pre-existing IBS, GERD, allergic rhinitis, and chronic dermatitis are speculative and fundamentally at odds with the Kaiser Permanente records. Because there is no objective medical evidence of pre-existing functional limitations, those conditions do not qualify as labor-disabling impairments for the purposes of an SIBTF award.

Accordingly, as our decision after reconsideration, we affirm the Findings of Fact.

For the foregoing reasons,

IT IS ORDERED, as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that the May 24, 2022 Findings of Fact is **AFFIRMED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

I CONCUR,

/s/ JOSEPH V. CAPURRO, COMMISSIONER



/s/ JOSÉ H. RAZO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MARCH 3, 2026

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

**VIVIANA GREENE
FARNSWORTH LAW GROUP, APC
OFFICE OF THE DIRECTOR – LEGAL UNIT**

DLP/md

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

REPORT AND RECOMMENDATION ON
PETITION FOR RECONSIDERATION

INTRODUCTION

On June 20, 2022, the Applicant filed a timely and verified Petition for Reconsideration alleging that the documentary and testimonial evidence should have compelled me to find that she was entitled to a permanent disability Award of 100%, less credits, from the Subsequent Injuries Benefits Trust Fund (SIBTF).

The Applicant, while employed on November 4, 2010, as a health inspector, Occupation Group Number 251, at Marin County, California, by the County of Marin, sustained a subsequent injury which arose out of and in the course of employment to the lumbar spine, lower extremities, and psyche.

Stipulations with Request for Award on the November 4, 2010 specific injury resulted in a 73% permanent disability Award issued September 6, 2019. The parties stipulated to a preexisting industrial ankle injury of July 23, 2009 which rated to 3% permanent disability. On May 24, 2022, I found pre-existing permanent disability of 22% due to asthma and awarded permanent disability of 98% from the Subsequent Injuries Benefits Trust Fund, less credits under Labor Code section 4753 to be adjusted by the parties.

The Applicant filed her petition for reconsideration contending that I erred in not finding the applicant 100 percent disabled based on the reporting of Dr. Anderson, the reporting of vocational expert Maria Brady, and the testimony of the applicant. In particular, the Applicant emphasized I erred in not finding pre-existing disability from allergic rhinitis, IBS, GERD, and rash/dermatitis, and that these pre-existing disabilities would result in 100 percent permanent disability.

THE PETITION DOES NOT PROPERLY CITE TO THE EVIDENTIARY RECORD

Title 8 California Code of Regulations section 10945 states the requirements for a Petition for Reconsideration, including that:

“(b) Every petition and answer shall support its evidentiary statements by specific references to the record.

(1) References to any stipulations, issues or testimony contained in any Minutes of Hearing, Summary of Evidence or hearing transcript shall specify:

(A) The date and time of the hearing; and

(B) If available, the page(s) and line number(s) of the Minutes, Summary, or transcript to which the evidentiary statement relates (e.g., “Summary of Evidence, 5/1/08 trial, 1:30pm session, at 6:11-6:15”).

(2) References to any documentary evidence shall specify:

(A) The exhibit number or letter of the document;

(B) Where applicable, the author(s) of the document;

(C) Where applicable, the date(s) of the document; and

(D) The relevant page number(s) (e.g., “Exhibit M, Report of John A. Jones, M.D., 6/16/08 at p. 7.”).

Title 8 California Code of Regulations section 10972 provides that, “[a] petition for reconsideration, removal or disqualification may be denied or dismissed if it is unsupported by specific references to the record and to the principles of law involved.”

Although applicant’s Petition for Reconsideration will occasionally reference exhibits with some specificity, such as a reference to “Exhibit 1, Pg. 13” (Applicant’s Petition for Reconsideration, page 5, line 16,) these references are sometimes missing. (*Id.* at page 9, lines 16-21.) The Applicant does identify that the Kaiser records she is referencing were reviewed by Dr. Anderson, and that the quotes are from Dr. Anderson’s summaries of those records, rather than the records themselves. (*Id.* at page 10, lines 1-3.) Furthermore, the applicant’s Petition for Reconsideration does not specify where in Dr. Anderson’s report the reference may be found. (*See for example, Id.* at page 10, lines 5-8.)

Because of the failure to specifically reference the evidentiary record, Applicant’s Petition for Reconsideration should be denied. Notwithstanding the foregoing, Applicant’s Petition should be denied upon its merits as well, as discussed below.

THE LAW

Eligibility for SIBTF benefits is governed by Labor Code section 4751, which provides as follows:

“If an employee who is permanently partially disabled receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to 70 percent or more of total, he shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury compensation for the remainder of the combined permanent disability existing after the last injury as provided in this article; provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg, or an eye, and the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such latter permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to 5 percent or more of total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35 percent or more of total.” (Labor Code § 4751.)

It is the applicant’s burden to prove that she meets all of the requirements to receive benefits under Labor Code § 4751. (*Brown v. Workers' Comp. Appeals Bd.* (1971) 20 Cal.App.3d 903, 915.) In the *en banc* decision of *Escobedo v. Marshalls, CNA Ins. Co.* (2005) 70 Cal. Comp. Cases 604 (WCAB *en banc*), the Board stated,

“[T]he chief requirement for SIF benefits is that the condition must have been "labor disabling" prior to the occurrence of the subsequent industrial injury. [Citations] Accordingly, if an applicant's non-industrial pathology causes apportionable permanent disability under section 4663 or 4664(a), then SIF benefits will not be payable under section 4751 unless the applicant demonstrates that the pathology was causing permanent disability prior to the subsequent industrial injury. Although this may mean that, in some cases, an injured employee will not get either permanent disability benefits or SIF benefits for the apportioned disability, this is not a major change from pre-SB 899 law, which held that an injured employee was not entitled to SIF benefits

based on an asymptomatic disease process that was not labor disabling prior to the industrial injury. (*Escobedo v. Marshalls, CNA Ins. Co.* (2005) 70 Cal. Comp. Cases 604, 619 (WCAB *en banc*).)

The pre-existing disability may be established by a prior award or by medical evidence. (*Todd v. Subsequent Injuries Benefits Trust Fund* (2020) 85 Cal. Comp. Cases 576, 581 (WCAB *en banc*).)

DISCUSSION

APPLICANT’S ASSERTION OF 100% DISABILITY BASED ON REPORTING OF SCOTT ANDERSON, M.D.

The applicant also relies on the medical record to establish permanent disability pre-existing the November 4, 2010 subsequent injury. Scott Anderson, M.D. performed his Subsequent Injuries Benefits Trust Fund Evaluation on December 4, 2020, and produced a report of the same date. I do not find Dr. Anderson’s reporting, or the records reviewed by Dr. Anderson, to be substantial evidence of permanent disability pre-existing the November 4, 2010 injury from vestibular dysfunction, GERD, IBS, allergic rhinitis, dermatitis, headaches, fibromyalgia, or obesity. Since I did find pre-existing disabilities as a result of asthma and an ankle injury, applicant does not dispute that finding.

Dr. Anderson provided impairments for vestibular dysfunction, GERD, IBS, allergic rhinitis, dermatitis, headaches, fibromyalgia, or obesity, that were “applicable immediately prior to the injurious events of November 4, 2010.” (Applicant’s Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, pages 54-55.) It is important to note that the records relied on by Dr. Anderson were not admitted into evidence. Without seeing the records, it is unknown whether there were contrary or contradicting statements in the records, or what important facts may have been in the records but not discussed in Dr. Anderson’s summary of the records. Even taking Dr. Anderson’s summaries to be accurate reflections of those records, I do not find his impairment ratings supported. Moreover, Dr. Anderson did not discuss specific time frames when disability from the applicant’s various conditions first manifested, or became permanent. Although Dr. Anderson stated that the impairment ratings he provided were for the period prior to the 2010 subsequent injury, the ratings indicate this is not the case.

After stating his pre-November 4, 2010 impairment ratings, he then provides apportionment to the ratings for fibromyalgia, migraine headaches, obesity, and vestibular dysfunction as 40% industrial and 60% as pre-existing internal medicine conditions. (Applicant’s Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 55.) Because he apportions some of his ratings to the subsequent industrial injury, it shows the impairment ratings he provided were not for disability as it existed before the November 4, 2010 subsequent injury, but instead incorporate industrial exacerbation and progression of conditions after November 4, 2010.

The few comments Dr. Anderson gives regarding his ratings also undermine that the ratings are of applicant’s condition as it existed prior to the subsequent injury. In rating vestibular dysfunction Dr. Anderson assigned a Class III vestibular disorder “in light of the fact that she has significant instability that has over the years required use of supportive devices.” (Applicant’s Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 54). The applicant presented to Dr. Anderson’s office using ski poles for stability in 2020. (*Id.* at page 5). There is no evidence the applicant used assistive devices for balance issues prior to the November 4, 2010

subsequent injury. The applicant used orthotic shoe inserts for an indeterminate period of time in around January 2009 for treatment of plantar fasciitis in the left foot, but there is not evidence in the record that she used orthotics for vestibular disorder. (*Id.* at page 15.) The applicant also used assistive devices related to her industrial ankle injury of July 23, 2009 for which the parties already stipulated to 3 percent pre-existing permanent disability. The records reviewed by Dr. Anderson between the July 23, 2009 ankle injury, and the November 4, 2010 subsequent injury only discussed use of braces, casts, canes, and crutches as related to the ankle injury, and not due to balance problems associated with vestibular dysfunction. (*Id.* at pages 16-22.) Therefore it appears Dr. Anderson's impairment rating for vestibular dysfunction is based on her condition as he saw her in 2020, and not her condition prior to November 4, 2010, because it is only after the subsequent injury that she used assistive devices for balance difficulty.

Dr. Anderson also stated that there was an obesity impairment prior to the subsequent injury, but that it was subsumed under the asthma and fibromyalgia ratings. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 54.) Although there are references to obesity prior to the subsequent injury in treatment records, Dr. Anderson stated that her body weight had increased after the accident, and prior to that she had a fairly normal body weight. (*Id.* at page 6.) It is therefore not clear that his comments on obesity disability are for her condition when he evaluated her in 2020, or for the period prior to the November 4, 2010 injury.

Based on these examples, the impairment ratings provided by Dr. Anderson are not, on their own, substantial evidence of pre-existing disability for vestibular dysfunction, GERD, IBS, allergic rhinitis, dermatitis, headaches, fibromyalgia, or obesity, because the ratings appear based on the applicant's conditions in 2020 rather than just prior to November 4, 2010.

Allergic Rhinitis

There is no diagnosis of allergic rhinitis before November 4, 2010. Dr. Anderson opined that the applicant had allergic rhinitis which was misdiagnosed as sinusitis. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 8.) As indicated by the applicant in her Petition for Reconsideration, there are numerous references to respiratory difficulties, including cough with phlegm before November 4, 2010. (Applicant's Petition for Reconsideration, page 10, line 5 – page 15, line 27.) However, these episodes of coughing appear to frequently be, although not always, assessed as acute exacerbations of the applicant's asthma. For example, on January 20, 2009 the applicant presented with a cough and phlegm symptoms, and the diagnosis was of asthma with acute exacerbation. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 13.) Laura Eberhard, M.D. saw the applicant on January 24, 2008 when the applicant had a cough for 6 weeks and suspected the applicant may have a subacute/chronic sinus infection that was exacerbating her asthma. (*Id.* at page 11.) She later diagnosed the applicant with a chronic sinusitis in addition to the asthma. (*Id.* at page 14.) The applicant's spirometry and pulmonary function tests were normal. (*Id.* at pages 8 and 10.)

There was a three day period from January 20 to January 22, 2009 where the applicant was off-work due to cough with phlegm. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 13.) However, the diagnosis was of asthma with acute exacerbation so this period of disability would support the 22% disability found for asthma, rather than allergic rhinitis. (*Id.* at 13.)

Despite the existence of these respiratory difficulties, they do not support an impairment rating under the *AMA Guides* beyond the 22% permanent disability already found for asthma. The *AMA Guides* rate respiratory disorders using Table 5-12 on page 107 - Impairment Classification for Respiratory Disorders, Using Pulmonary Function and Exercise Test Results. Because the

applicant's pulmonary function and spirometry tests were normal, there would be no impairment using Table 5-12 of the *AMA Guides*.

For his diagnosis of allergic rhinitis Dr. Anderson used Table 11-6 Criteria for Rating Impairment Due to Air Passage Defects, on page 260 of the *AMA Guides*, and assigns a Class I 3% WPI. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020,, page 54.) For a Class I impairment there are four required elements, including that "examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi, or complete (bilateral) obstruction of the nose or nasopharynx." However, Dr. Anderson did not identify evidence of such an obstruction, and stated the applicant had no history of obstructive sinusitis (which Dr. Anderson opined was misdiagnosed allergic rhinitis) so a rating under Table 11-6 is not appropriate. (*Id.* at page 8.) Therefore there is no substantial evidence to support permanent disability due to sinusitis/allergic rhinitis prior to the November 4, 2010 subsequent injury.

Gastroesophageal Reflux Disease (GERD)

There is a diagnosis of GERD prior to the November 4, 2010 subsequent injury, and occasional intestinal and stomach complaints. The diagnosis of GERD is inconsistent in the medical record summaries prior to November 4, 2010. Applicant's Petition for Reconsideration indicates the applicant was prescribed a proton pump inhibitor in 2009 and recommended Pepcid. (Applicant's Petition for Reconsideration, page 9, lines 2-3.) Applicant also asserts the records show she was taking Omeprazole and was treating for GERD through June 7, 2009. (*Id.* at page 9, lines 3-7.) I do not find any reference in pre-November 4, 2010 treatment reports to the use of Omeprazole, or to a 2009 recommendation to take Pepcid, either in the pages cited in applicant's Petition or in my own review of the evidence. The applicant continued to be diagnosed with GERD by Susan Gross, M.D. on June 7, 2009, but the applicant's complaints on that date were related to asthma and cough, and it was noted that the applicant had declined treatment for GERD. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 15.) The applicant did test positive for *H. pylori*. (*Id.* at page 9.)

The *AMA Guides* state that "[e]sophageal impairment signs and symptoms include dysphagia, pyrosis or heartburn, retrosternal pain, regurgitation, bleeding, and weight loss. Note that occasional, minor dyspepsia, gas, and belching are within the experience of all individuals." (*AMA Guides*, page 118.) GERD is rated using Table 6-3 Criteria for Rating Permanent Impairment Due to Upper Digestive Tract on page 121 of the *AMA Guides*. For a Class I impairment, which ranges from 0% to 9% whole person impairment, the criteria are, "Symptoms or signs of upper digestive tract disease, *or* anatomic loss or alteration *and* continuous treatment not required *and* maintains weight at desirable level *or* no sequelae after surgical procedures." Although there are complaints of upset stomach, gas, and bloating noted in the pre-November 4, 2010 treatment record summaries, there are not symptoms of dysphagia, pyrosis or heartburn, retrosternal pain, regurgitation, bleeding, and weight loss. There is a reference to epigastric pain and bloating in the summary of a November 6, 2007 treatment report, where the applicant was recommended a trial of proton pump inhibitors. (Applicant's Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, pages 9-10.) There is an additional reference to epigastric pain on January 21, 2008, but it is not clear if this reference is for pyrosis or heartburn because the applicant's complaints are of lung pain that felt like broken ribs. (*Id.* at page 10.) There are no further references elsewhere to epigastric pain or heartburn prior to November 4, 2010.

The case examples on page 121 of the *AMA Guides* are instructive in evaluating potential permanent disability prior to the subsequent injury. Example 6-1 is an individual with no current symptoms of esophageal disease who is assigned a 0% whole person impairment. Example 6-2 is also instructive:

“History: 5 years’ epigastric pain and burning. Minimal weight loss.

Current Symptoms: Denied nausea, vomiting, hematemesis, or melena. Painful episodes last up to 2 weeks, wake him at night, and require antacids, food, and over-the-counter (OTC) H2 blockers for relief. Avoided all ulcerogenic drugs.

Physical Exam: Height: 1.8 m (5 ft 11 in); weight: 72.6 kg (160 lb).

Clinical Studies: Barium meal: deformed duodenal bulb. No gastric retention or pyloric stenosis. Peroral endoscopy: scar of healed ulcer on posterior wall on first portion of duodenum. Endoscopy: 1-cm duodenum ulcer-crater; considerable surrounding deformity. Antral biopsies: positive for *H. pylori*; full-course triple-therapy (omeprazole, clarithromycin, and metronidazole) relieved symptoms. Complete healing at followup endoscopy 8 weeks later. Repeat antrum and body biopsies: no *H. pylori*.

Diagnosis: Resolved peptic duodenal ulcer disease associated with *H. pylori* infection.

Impairment Rating: 0% if remission continues.” (*AMA Guides*, pages 121-122.)

This case example is similar to the symptoms suffered by the applicant, and would support a finding of 0% impairment. The applicant’s medical history, without indications of ongoing dysphagia, pyrosis or heartburn, retrosternal pain, regurgitation, bleeding, or weight loss, especially in consideration of the *AMA Guides* examples, does not support a permanent disability for the applicant’s GERD prior to the subsequent injury.

Irritable Bowel Syndrome (IBS)

The record also does not support a finding of permanent disability for IBS prior to the November 4, 2010 injury. There is no diagnosis of that condition prior to the subsequent injury, and symptoms are not consistent in the treatment reports prior to the November 4, 2010 injury. Again, the case examples in the *AMA Guides* are instructive. Example 6-18 has a history of, “[s]everal years’ tendency of mildly erratic bowel action with alternating constipation and diarrhea. Stools of varied consistency never contained abnormal materials.” (*AMA Guides*, page 128.) Despite current complaints of “[e]pisodes of cramping bowel movements; alternating diarrhea and constipation...” the Guides assign a 0% impairment of the whole person for case example 6-18. (*Id.* at page 128.) Given the applicant’s medical record this example supports a finding that there is no permanent disability due to IBS prior to the November 4, 2010 subsequent injury.

Dermatitis / Rash

On March 31, 2009, the applicant developed dermatitis, which was diagnosed to be a result of shingles. (Applicant’s Exhibit 1 - Report of Scott Anderson, M.D., dated December 4, 2020, page 14.) On April 1, 2009 the applicant followed-up for the trunk pain associated with shingles, but there was no discussion of dermatitis. (*Id.* at page 15.) There is no discussion of rash or dermatitis again in the medical record until February 19, 2010. On that date the applicant presented

with papules on her face and armpit and the applicant was provided treatment recommendations and advised to follow up. (*Id.* at page 21.) There is no evidence the applicant followed up for further treatment, or that the condition continued. These two incidents, with no evidence of on-going complaints, are not sufficient to support a finding of permanent disability for dermatitis.

After consideration of the Applicant's argument in her Petition for Reconsideration, and review of the evidence, I find no evidence for any pre-existing permanent disability besides the 3% for the July 23, 2009 ankle injury and 22% for asthma. Therefore after adding the 73% disability for the November 10, 2022 subsequent injury, my finding 98% disability is supported by the evidence.

APPLICANT'S ASSERTION OF 100% DISABILITY BASED ON REPORTING OF VOCATIONAL EXPERT MARIA BRADY

Applicant contends a finding of 100% permanent disability should be found based on the reporting of vocational expert Maria Brady. (Applicant's Petition for Reconsideration, page 2, lines 10-14.) Maria Brady stated in her June 8, 2017 report that the applicant's industrial injuries alone resulted in her 73% diminished future earning capacity and she would have been amenable to rehabilitation as a result of the industrial injury alone. (Applicant's Exhibit 3 –Report of Vocational Expert Maria Brady dated June 8, 2017,page 14.) Ms. Brady went on to state that when considering the applicant's problems with dizziness, vertigo, and headaches, that it was not likely she would be able to maintain employment. (*Id.* at page 14.)

While these conditions of dizziness, vertigo, and headaches may mean the applicant is unable to work, there is not substantial evidence these conditions pre-existed the November 4, 2010 injury. It is noted that the applicant testified at trial that these conditions were present before the November 4, 2010 injury. However, there are no treatment reports in the record substantiating dizziness, vertigo, and headaches before November 4, 2010. In addition, the applicant on multiple occasions told treating and evaluating physicians that these conditions were the result of the November 4, 2010 injury. In her June 8, 2017 report, Maria Brady stated that the applicant reported no non-industrial health issues, indicating that at the time of the evaluation with Ms. Brady, the applicant perceived the dizziness, vertigo, and headache conditions to be industrial. (Applicant's Exhibit 3 –Report of Vocational Expert Maria Brady dated June 8, 2017,page 4.) Ms. Brady also stated that the applicant claimed her problems with constant dizziness developed after the November 4, 2010 injury. (*Id.* at page 9.) In her statements to Dr. Jamasbi, the applicant denied experiencing headaches prior to the November 4, 2010 subsequent injury. (Applicant's Exhibit 25, Report of Babak Jamasbi, M.D., dated October 31, 2012, page 18.) According to the neurology consultant Dr. Lo, the applicant denied "... any prior history of headaches, vertigo, or sensation of imbalance prior to her second work-related injury on 11/04/10." (Applicant's Exhibit 20, Report of Timothy Lo, M.D., dated November 7, 2012, page 3.) At a September 16, 2013 appointment with treating neurologist Tracy Newkirk, M.D. the applicant indicated that she had "... no headache before the injury or at most one a year. When she had a headache they were mild and she never took medication." (Applicant's Exhibit 14 – Report of Tracy Newkirk, M.D., dated September 16, 2013, page 3.) Dr. Newkirk's diagnosis was of post-traumatic vertigo. (*Id.* at page 4.)

Because the dizziness, vertigo, and headaches conditions did not pre-date her industrial injury, they are not subject to SIBTF liability, and Maria Brady's finding of 100% disability is not

subject to SIBTF liability since all contributions to that disability determination are from the November 4, 2010 subsequent injury, or conditions and disabilities developing after that injury.

**APPLICANT’S ASSERTION OF 100% DISABILITY BASED ON HER TESTIMONY OF
PRE-EXISTING DISABILITY**

The applicant asserts that her testimony regarding her medical history was credible, uncontradicted, unimpeached, and supported pre-existing disability to support 100 percent disability. (Applicant’s Petition for Reconsideration, page 16, line 3 – page 18, line 1.) I did not find the applicant’s testimony regarding her medical history credible or persuasive. The applicant’s testimony that dizziness, vertigo, and headaches pre-dated her November 4, 2010 injury is contradicted by her statements to multiple doctors and evaluators as discussed above. The assertion is also not supported by the medical record as there are not references to those conditions prior to the subsequent injury. The inconsistency regarding dizziness, vertigo, and headaches undermines the applicant’s credibility and testimony regarding her entire medical history, and that she had disability pre-existing November 4, 2010 due to vestibular dysfunction, GERD, IBS, allergic rhinitis, dermatitis, headaches, fibromyalgia, or obesity. As a result, the applicant’s testimony is not sufficient evidence to support 100 percent disability, especially since it is not backed up by contemporaneous medical reports (obtained prior to the subsequent injury) which were admitted into evidence.

RECOMMENDATION

For the foregoing reasons, I recommend that the Petition for Reconsideration of applicant, filed herein on June 20, 2022, be DENIED.

DATE: July 5, 2022

Lawrence Keller
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE